

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

## Filing at a Glance

Company: Heartland National Life Insurance Company

Product Name: Medicare Supplement SERFF Tr Num: ETPF-125992439 State: ArkansasLH

TOI: MS051 Individual Medicare Supplement - SERFF Status: Closed State Tr Num: 41383

Standard Plans

Sub-TOI: MS051.001 Plan A

Co Tr Num: 90000 AR

State Status: Approved-Closed

Filing Type: Form/Rate

Co Status: Submitted

Reviewer(s): Stephanie Fowler

Authors: Mark Banks, Jana

Disposition Date: 07/10/2009

Peterson, Kathy Foster

Date Submitted: 01/20/2009

Disposition Status: Approved-Closed

Implementation Date Requested: 03/03/2009

Implementation Date:

State Filing Description:

## General Information

Project Name: 90000

Status of Filing in Domicile: Not Filed

Project Number: 90000

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 07/10/2009

Explanation for Other Group Market Type:

State Status Changed: 02/13/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Submitted for your review are the following Medicare Supplement forms for Heartland National Life Insurance Company:

Form Number Form Type

90000-A AR

Plan A Policy

<i>SERFF Tracking Number:</i>	<i>ETPF-125992439</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Heartland National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>41383</i>
<i>Company Tracking Number:</i>	<i>90000 AR</i>		
<i>TOI:</i>	<i>MS051 Individual Medicare Supplement - Standard Plans</i>	<i>Sub-TOI:</i>	<i>MS051.001 Plan A</i>
<i>Product Name:</i>	<i>Medicare Supplement</i>		
<i>Project Name/Number:</i>	<i>90000/90000</i>		
<b>90000-D AR</b>	<b>Plan D Policy</b>		
<b>90000-F AR</b>	<b>Plan F Policy</b>		
<b>90000-G AR</b>	<b>Plan G Policy</b>		
<b>A-HNL 08 AR</b>	<b>Application</b>		
<b>HNL-MQ-08</b>	<b>Medical Questions</b>		
<b>OLC 90000 AR</b>	<b>Outline of Coverage</b>		
<b>HRN-07</b>	<b>Replacement Notice</b>		
<b>HPF-AR</b>	<b>Consumer Information Form</b>		

Heartland National Life Insurance Company (“Heartland”) is a life and health insurer domiciled in Indiana. Heartland recently acquired Dixie National Life Insurance Company (“Dixie”), an insurer licensed in Arkansas. The NAIC number for Dixie, which has been retained by Heartland, is #66214. A Corporate Amendments Application has been submitted to the Arkansas Insurance Department (“Department”) to officially change the company name from Dixie to Heartland and is currently under review. The forms submitted in this filing are Heartland forms. These forms, should they be approved for use prior to the approval of the company name change, will not be used until such time that the company name change has been approved. A certification to this position is included in this filing.

The forms in this filing are new forms, and do not replace any form previously filed with the Department. These are individual policies and will be marketed through licensed and appointed producers. These policies will be administered by a Third Party Administrator, Equitable Life and Casualty Insurance Company (“Equitable”).

Each form in this filing is briefly described as follows:

**Policy Forms:** The policy form is the contract of insurance. The policy provides the benefits required under state law, as applicable. The policy is guaranteed renewable and does not contain a waiting period for pre-existing conditions.

**Application:** The application is used to gather information necessary for the issuance of a policy. Such information includes an applicant’s plan selection, if the applicant is eligible for coverage as an open enrollee or under a guarantee issue situation, and the disclosures and questions required under state law.

**Medical Information:** Individuals who do not apply during their open enrollment periods or under circumstances that



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Product Name: Medicare Supplement  
Project Name/Number: 90000/90000

## Filing Fees

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

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
11845917	\$50.00	01/20/2009

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 Product Name: Medicare Supplement  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	07/10/2009	07/10/2009
Approved-Closed	Stephanie Fowler	07/01/2009	07/01/2009
Approved-Closed	Stephanie Fowler	02/13/2009	02/13/2009
Approved-Closed	Stephanie Fowler	02/13/2009	02/13/2009

### 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	02/13/2009	02/13/2009	Jana Peterson	02/13/2009	02/13/2009
Pending Industry Response	Stephanie Fowler	02/11/2009	02/11/2009	Jana Peterson	02/12/2009	02/12/2009
Pending Industry Response	Stephanie Fowler	02/03/2009	02/03/2009	Jana Peterson	02/04/2009	02/04/2009

### Amendments

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
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 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

Item	Schedule	Created By	Created On	Date Submitted
Page 3, Medicare Supplement Policy Plan F Endorsement Form	Form	Jana Peterson	07/06/2009	07/06/2009
Redlined Plan Supporting Document F Page 3		Jana Peterson	07/06/2009	07/06/2009
Application - Medicare Supplement Insurance	Form	Jana Peterson	06/23/2009	06/23/2009
6-23-09 Redlined Application	Supporting Document	Jana Peterson	06/23/2009	06/23/2009
Medicare Supplement Policy Plan F	Form	Jana Peterson	02/13/2009	02/13/2009
<b>Filing Notes</b>				

Subject	Note Type	Created By	Created On	Date Submitted
Filing reopened	Note To Filer	Stephanie Fowler	02/13/2009	02/13/2009
Error	Note To Reviewer	Jana Peterson	02/13/2009	02/13/2009



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 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Form and Rate Certification	Accepted for Informational Purposes	Yes
Supporting Document	Third Party Authorization	Accepted for Informational Purposes	Yes
Supporting Document	Redlined Copies	Accepted for Informational Purposes	Yes
Supporting Document	6-23-09 Redlined Application	Accepted for Informational Purposes	Yes
Supporting Document	Redlined Plan F Page 3	Approved	Yes
Form (revised)	Medicare Supplement Policy Plan a	Approved	Yes
Form (revised)	Medicare Supplement Policy Plan D	Approved	Yes
Form (revised)	Medicare Supplement Policy Plan F	Approved	Yes
Form	Medicare Supplement Policy Plan F	Disapproved	Yes
Form (revised)	Medicare Supplement Policy Plan G	Approved	Yes
Form (revised)	Application - Medicare Supplement Insurance	Approved	Yes
Form	Application - Medicare Supplement Insurance	Approved	Yes
Form	Medical Questions	Approved	Yes
Form	Notice to Applicants Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage	Approved	Yes
Form (revised)	Outline of Coverage	Approved	Yes
Form	Important Notice	Approved	Yes
Form	Page 3, Medicare Supplement Policy Plan F	Approved	Yes
Form	Endorsement	Approved	Yes
Form	Medicare Supplement Policy Plan a	Disapproved	Yes

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

<b>Form</b>	Medicare Supplement Policy Plan D	Disapproved	Yes
<b>Form</b>	Medicare Supplement Policy Plan F	Disapproved	Yes
<b>Form</b>	Medicare Supplement Policy Plan G	Disapproved	Yes
<b>Form</b>	Application - Medicare Supplement Insurance	Disapproved	Yes
<b>Form</b>	Outline of Coverage	Disapproved	Yes
<b>Rate (revised)</b>	Actuarial Memorandum	Approved	No
<b>Rate</b>	Actuarial Memorandum	Disapproved	No
<b>Rate (revised)</b>	Rate Schedule	Approved	Yes
<b>Rate</b>	Rate Schedule	Disapproved	Yes





SERFF Tracking Number: ETPF-125992439 State: Arkansas  
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 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Form and Rate Certification	Accepted for Informational Purposes	Yes
Supporting Document	Third Party Authorization	Accepted for Informational Purposes	Yes
Supporting Document	Redlined Copies	Accepted for Informational Purposes	Yes
Supporting Document	6-23-09 Redlined Application	Accepted for Informational Purposes	Yes
Supporting Document	Redlined Plan F Page 3	Approved	Yes
Form (revised)	Medicare Supplement Policy Plan a	Approved	Yes
Form (revised)	Medicare Supplement Policy Plan D	Approved	Yes
Form (revised)	Medicare Supplement Policy Plan F	Approved	Yes
Form	Medicare Supplement Policy Plan F	Disapproved	Yes
Form (revised)	Medicare Supplement Policy Plan G	Approved	Yes
Form (revised)	Application - Medicare Supplement Insurance	Approved	Yes
Form	Application - Medicare Supplement Insurance	Approved	Yes
Form	Medical Questions	Approved	Yes
Form	Notice to Applicants Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage	Approved	Yes
Form (revised)	Outline of Coverage	Approved	Yes
Form	Important Notice	Approved	Yes
Form	Page 3, Medicare Supplement Policy Plan F	Approved	Yes
Form	Endorsement	Approved	Yes
Form	Medicare Supplement Policy Plan a	Disapproved	Yes

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

<b>Form</b>	Medicare Supplement Policy Plan D	Disapproved	Yes
<b>Form</b>	Medicare Supplement Policy Plan F	Disapproved	Yes
<b>Form</b>	Medicare Supplement Policy Plan G	Disapproved	Yes
<b>Form</b>	Application - Medicare Supplement Insurance	Disapproved	Yes
<b>Form</b>	Outline of Coverage	Disapproved	Yes
<b>Rate (revised)</b>	Actuarial Memorandum	Approved	No
<b>Rate</b>	Actuarial Memorandum	Disapproved	No
<b>Rate (revised)</b>	Rate Schedule	Approved	Yes
<b>Rate</b>	Rate Schedule	Disapproved	Yes





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 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Form and Rate Certification	Accepted for Informational Purposes	Yes
Supporting Document	Third Party Authorization	Accepted for Informational Purposes	Yes
Supporting Document	Redlined Copies	Accepted for Informational Purposes	Yes
Supporting Document	6-23-09 Redlined Application	Accepted for Informational Purposes	Yes
Supporting Document	Redlined Plan F Page 3	Approved	Yes
Form (revised)	Medicare Supplement Policy Plan a	Approved	Yes
Form (revised)	Medicare Supplement Policy Plan D	Approved	Yes
Form (revised)	Medicare Supplement Policy Plan F	Approved	Yes
Form	Medicare Supplement Policy Plan F	Disapproved	Yes
Form (revised)	Medicare Supplement Policy Plan G	Approved	Yes
Form (revised)	Application - Medicare Supplement Insurance	Approved	Yes
Form	Application - Medicare Supplement Insurance	Approved	Yes
Form	Medical Questions	Approved	Yes
Form	Notice to Applicants Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage	Approved	Yes
Form (revised)	Outline of Coverage	Approved	Yes
Form	Important Notice	Approved	Yes
Form	Page 3, Medicare Supplement Policy Plan F	Approved	Yes
Form	Endorsement	Approved	Yes
Form	Medicare Supplement Policy Plan a	Disapproved	Yes

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

<b>Form</b>	Medicare Supplement Policy Plan D	Disapproved	Yes
<b>Form</b>	Medicare Supplement Policy Plan F	Disapproved	Yes
<b>Form</b>	Medicare Supplement Policy Plan G	Disapproved	Yes
<b>Form</b>	Application - Medicare Supplement Insurance	Disapproved	Yes
<b>Form</b>	Outline of Coverage	Disapproved	Yes
<b>Rate (revised)</b>	Actuarial Memorandum	Approved	No
<b>Rate</b>	Actuarial Memorandum	Disapproved	No
<b>Rate (revised)</b>	Rate Schedule	Approved	Yes
<b>Rate</b>	Rate Schedule	Disapproved	Yes





SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Form and Rate Certification	Accepted for Informational Purposes	Yes
Supporting Document	Third Party Authorization	Accepted for Informational Purposes	Yes
Supporting Document	Redlined Copies	Accepted for Informational Purposes	Yes
Supporting Document	6-23-09 Redlined Application	Accepted for Informational Purposes	Yes
Supporting Document	Redlined Plan F Page 3	Approved	Yes
Form (revised)	Medicare Supplement Policy Plan a	Approved	Yes
Form (revised)	Medicare Supplement Policy Plan D	Approved	Yes
Form (revised)	Medicare Supplement Policy Plan F	Approved	Yes
Form	Medicare Supplement Policy Plan F	Disapproved	Yes
Form (revised)	Medicare Supplement Policy Plan G	Approved	Yes
Form (revised)	Application - Medicare Supplement Insurance	Approved	Yes
Form	Application - Medicare Supplement Insurance	Approved	Yes
Form	Medical Questions	Approved	Yes
Form	Notice to Applicants Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage	Approved	Yes
Form (revised)	Outline of Coverage	Approved	Yes
Form	Important Notice	Approved	Yes
Form	Page 3, Medicare Supplement Policy Plan F	Approved	Yes
Form	Endorsement	Approved	Yes
Form	Medicare Supplement Policy Plan a	Disapproved	Yes

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
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 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
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 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

<b>Form</b>	Medicare Supplement Policy Plan D	Disapproved	Yes
<b>Form</b>	Medicare Supplement Policy Plan F	Disapproved	Yes
<b>Form</b>	Medicare Supplement Policy Plan G	Disapproved	Yes
<b>Form</b>	Application - Medicare Supplement Insurance	Disapproved	Yes
<b>Form</b>	Outline of Coverage	Disapproved	Yes
<b>Rate (revised)</b>	Actuarial Memorandum	Approved	No
<b>Rate</b>	Actuarial Memorandum	Disapproved	No
<b>Rate (revised)</b>	Rate Schedule	Approved	Yes
<b>Rate</b>	Rate Schedule	Disapproved	Yes

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
Company Tracking Number: 90000 AR  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement  
Project Name/Number: 90000/90000

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/13/2009  
Submitted Date 02/13/2009  
Respond By Date 03/13/2009

Dear Jana Peterson,

Thank you for your quick response, this will acknowledge receipt of the captioned filing. It seems that the revised Actuarial Memorandum and the revised Application were not attached.

Please feel free to contact me if you have questions.

Sincerely,  
Stephanie Fowler

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 02/13/2009  
Submitted Date 02/13/2009

Dear Stephanie Fowler,

### Comments:

I attached them in the draft mode, however they didn't get sent.

### Response 1

Comments: Here is the revised Application and Actuarial Memorandum

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: Redlined Copies

Comment:

#### Form Schedule Item Changes

Form Name	Form	Edition	Form Type	Action	Action	Readability Attach
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SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
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 Project Name/Number: 90000/90000

	Number	Date		Specific Data	Score	Document
Application - Medicare Supplement Insurance	A-HNL 08 AR		Application/Enrollment Form	Initial		A-HNL 08 AR.pdf
<b>Previous Version</b>						
Application - Medicare Supplement Insurance	A-HNL 08 AR		Application/Enrollment Form	Initial		app-90020_ar.pdf

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
Company Tracking Number: 90000 AR  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement  
Project Name/Number: 90000/90000

**Rate/Rule Schedule Item Changes**

**Document Name: Affected Form Numbers: Rate Action: Rate Action Information: Attach Document:**

Actuarial 90020-A AR, 90020-D AR, New Previous State Filing Number  
Memorandum 90020-F AR, 90020-G AR  
Percent Rate Change Request  
0

**Previous Version**

Actuarial 90020-A AR, 90020-D AR, New Previous State Filing Number  
Memorandum 90020-F AR, 90020-G AR  
Percent Rate Change Request  
0

Please accept my apologies - this new response system is taking some getting used to...

Sincerely,  
Jana Peterson, Kathy Foster, Mark Banks

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
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Company Tracking Number: 90000 AR  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement  
Project Name/Number: 90000/90000

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/11/2009  
Submitted Date 02/11/2009  
Respond By Date 03/11/2009

Dear Jana Peterson,

This will acknowledge receipt of the captioned filing. Thank you for quickly sending the remaining filing fee, please see my comments below.

### Objection 1

- Medicare Supplement Policy Plan a (Form)
- Medicare Supplement Policy Plan D (Form)
- Medicare Supplement Policy Plan F (Form)
- Medicare Supplement Policy Plan G (Form)

Comment: AR Code Ann. 23-79-109(a)(4) states, "all Medicare supplement rates shall be based on a composite age basis only, and shall not be based on any age banding or other groupings." With that being stated, please revise the Premium Changes provision on the cover page and the language reflected for the Premium on the Policy Schedule page.

### Objection 2

- Medicare Supplement Policy Plan a (Form)
- Medicare Supplement Policy Plan D (Form)
- Medicare Supplement Policy Plan F (Form)
- Medicare Supplement Policy Plan G (Form)

Comment: Please remove the Misstatement of Age provision, as it would not apply to the citizens of Arkansas, per AR Code Ann. 23-79-109(a)(4).

### Objection 3

- Outline of Coverage (Form)

Comment: Please add "This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details." to the Notice provision on page 7 of this outline.

### Objection 4

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Project Name/Number: 90000/90000

- Rate Schedule (Rate)

Comment: AR Rule and Regulation 27 s6(C) states "No Medicare supplement policy or certificate may include a policy fee or any other similar charge. Applicants cannot be required to pay any fee other than the approved premium".

Please revise this filing to comply.

Please feel free to contact me if you have questions.

Sincerely,  
Stephanie Fowler

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	02/12/2009
Submitted Date	02/12/2009

Dear Stephanie Fowler,

### Comments:

Thank you for your review of Heartland National Life Insurance Company's recent submission of our new Medicare Supplement policies 90000-A AR, 90000-D AR, 90000-F AR and 90000-G AR et al. (SERFF Tracking # ETPF-125992439, Arkansas Tracking # 41383). We appreciate your timely response. We have received your objection letter dated February 11, 2009, and will answer your concerns in the order in which they were presented.

### Response 1

Comments: 1. To comply with AR Code Ann. 23-79-109(a)(4), the policy forms have all been revised.

a. Page 1 – Premium Changes- the phrase "and/or your age at entry" has been removed.

b. Page 2 – Policy Schedule – the phrase "See scale of attained age premiums on outline of coverage" has been removed.

### Related Objection 1

Applies To:

- Medicare Supplement Policy Plan a (Form)
- Medicare Supplement Policy Plan D (Form)
- Medicare Supplement Policy Plan F (Form)
- Medicare Supplement Policy Plan G (Form)

Comment:

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
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 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

AR Code Ann. 23-79-109(a)(4) states, "all Medicare supplement rates shall be based on a composite age basis only, and shall not be based on any age banding or other groupings." With that being stated, please revise the Premium Changes provision on the cover page and the language reflected for the Premium on the Policy Schedule page.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Medicare Supplement Policy Plan a	90000-A AR		Policy/Contract/Fraternal Certificate	Initial			90000-a_ar.pdf
<b>Previous Version</b>							
Medicare Supplement Policy Plan a	90000-A AR		Policy/Contract/Fraternal Certificate	Initial			90000-a_ar.pdf
Medicare Supplement Policy Plan D	90000-D AR		Policy/Contract/Fraternal Certificate	Initial			90000-d_ar.pdf
<b>Previous Version</b>							
Medicare Supplement Policy Plan D	90000-D AR		Policy/Contract/Fraternal Certificate	Initial			90000-d_ar.pdf
Medicare Supplement Policy Plan F	90000-F AR		Policy/Contract/Fraternal Certificate	Initial			90000-g_ar.pdf
<b>Previous Version</b>							
Medicare Supplement Policy Plan F	90000-F AR		Policy/Contract/Fraternal Certificate	Initial			90000-f_ar.pdf
Medicare Supplement Policy Plan G	90000-G AR		Policy/Contract/Fraternal Certificate	Initial			90000-g_ar.pdf
<b>Previous Version</b>							
Medicare Supplement Policy Plan G	90000-G AR		Policy/Contract/Fraternal Certificate	Initial			90000-g_ar.pdf

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
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 Standard Plans  
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 Project Name/Number: 90000/90000

No Rate/Rule Schedule items changed.

## Response 2

Comments: 2. To comply with AR Code Ann. 23-79-109(a)(4), the policy forms have all been revised.

a. Page 6 – Misstatement of Age – this provision has been removed.

### Related Objection 1

Applies To:

- Medicare Supplement Policy Plan a (Form)
- Medicare Supplement Policy Plan D (Form)
- Medicare Supplement Policy Plan F (Form)
- Medicare Supplement Policy Plan G (Form)

Comment:

Please remove the Misstatement of Age provision, as it would not apply to the citizens of Arkansas, per AR Code Ann. 23-79-109(a)(4).

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Medicare Supplement Policy Plan a	90000-A AR		Policy/Contract/Fraternal Certificate	Initial			90000-a_ar.pdf
<b>Previous Version</b>							
Medicare Supplement Policy Plan a	90000-A AR		Policy/Contract/Fraternal Certificate	Initial			90000-a_ar.pdf
Medicare Supplement Policy Plan D	90000-D AR		Policy/Contract/Fraternal Certificate	Initial			90000-d_ar.pdf
<b>Previous Version</b>							
Medicare Supplement Policy Plan D	90000-D AR		Policy/Contract/Fraternal Certificate	Initial			90000-d_ar.pdf
Medicare Supplement	90000-F		Policy/Contract/Fraternal	Initial			90000-

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans

Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

Policy Plan F AR Certificate g\_ar.pdf

**Previous Version**

Medicare Supplement 90000-F Policy/Contract/Fraternal Initial 90000-

Policy Plan F AR Certificate f\_ar.pdf

Medicare Supplement 90000-G Policy/Contract/Fraternal Initial 90000-

Policy Plan G AR Certificate g\_ar.pdf

**Previous Version**

Medicare Supplement 90000-G Policy/Contract/Fraternal Initial 90000-

Policy Plan G AR Certificate g\_ar.pdf

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

No Rate/Rule Schedule items changed.

### Response 3

Comments: 3. As requested, the Outline of Coverage form OLC 90000 AR has been revised.

a. Page 7 – Notice – the required language has been added.

#### Related Objection 1

Applies To:

- Outline of Coverage (Form)

Comment:

Please add "This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details." to the Notice provision on page 7 of this outline.

#### Changed Items:

No Supporting Documents changed.

#### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Outline of Coverage	OLC 90000 AR		Outline of Coverage	Initial			Olc90000-2009_ar.pdf
<b>Previous Version</b>							
Outline of Coverage	OLC 90000 AR		Outline of Coverage	Initial			Olc90000-2009_ar.pdf

No Rate/Rule Schedule items changed.

### Response 4

Comments: 4. To comply with AR Rule and Regulation 27 §6(C), the following changes have been made.

a. Both the Actuarial Memorandum and the Rate Sheets have been revised to remove any reference to a policy fee.

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
Company Tracking Number: 90000 AR  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement  
Project Name/Number: 90000/90000

- b. Application form A-HNL 08 AR has been revised to remove any reference to a policy fee.
- c. Outline of Coverage form OLC 90000 AR has been revised to remove any reference to a policy fee.

**Related Objection 1**

Applies To:

- Rate Schedule (Rate)

Comment:

AR Rule and Regulation 27 s6(C) states "No Medicare supplement policy or certificate may include a policy fee or any other similar charge. Applicants cannot be required to pay any fee other than the approved premium".

Please revise this filing to comply.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

**Rate/Rule Schedule Item Changes**

<b>Document Name:</b>	<b>Affected Form Numbers:</b>	<b>Rate Action:</b>	<b>Rate Action Information:</b>	<b>Attach Document:</b>
Rate Schedule	90020-A AR, 90020-D AR, 90020-F AR, 90020-G AR	New	<i>Previous State Filing Number</i>  <i>Percent Rate Change Request</i> 0	

**Previous Version**

<i>Rate Schedule</i>	<i>90020-A AR, 90020-D AR, 90020-F AR, 90020-G AR</i>	<i>New</i>	<i>Previous State Filing Number</i>  <i>Percent Rate Change Request</i> 0	
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Attached please find redlined as well as clean copies of all revised forms. With these revisions, we hope that this filing now meets with the approval of the Arkansas Insurance Department. We look forward to hearing from you soon.

Sincerely,

Jana Peterson, Kathy Foster, Mark Banks

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
Company Tracking Number: 90000 AR  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement  
Project Name/Number: 90000/90000

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/03/2009  
Submitted Date 02/03/2009  
Respond By Date 03/03/2009

Dear Jana Peterson,

This will acknowledge receipt of the captioned filing. The filing fees for this type of filing is \$50 for each policy including all associated forms. Please send additional required amount.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 02/04/2009  
Submitted Date 02/04/2009

Dear Stephanie Fowler,

### Comments:

#### Response 1

Comments: I am sending to your attention check # 1042 dated 2/4/09 via Fed X this afternoon.

Jana Peterson

Senior Compliance Specialist

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.



SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

**Amendment Letter**

Amendment Date:  
 Submitted Date: 07/06/2009

**Comments:**

Thank you for your approval of Heartland National Life Insurance Company's recent submission of our Medicare Supplement product filing Form 90000 A-G et al. (SERFF Tracking # ETPF-125992439), which was approved by the Arkansas Insurance Department on February 13, 2009.

We have discovered an error in this filing. The policy form Plan F should contain a Skilled Nursing Facility Care Benefit on Page 3 under the heading of Additional Benefits. We have corrected this error, and are submitting this Page 3 for approval.

At this time, we have sold 110 of this plan in your state. Attached is an endorsement (Form E-HSNF) for your approval which would correct the omission of the Skilled Nursing Benefit in those policies. With your approval, current policyowners will be sent either a corrected policy or the endorsement to attach to the policy they have received.

Attached please find a clean as well as a redlined copy of the Page 3 of the policy form and a copy of the endorsement we will use. We apologize for this error, and appreciate your timely response to help us correct it. We look forward to hearing from you soon.

**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
90000-F AR p 3	Policy/Contr act/Fraternal Certificate	Page 3, Medicare Supplement Policy Plan F	Initial					f_ar page 3.pdf

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
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SERFF Tracking Number: ETPF-125992439 State: Arkansas  
Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
Company Tracking Number: 90000 AR  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement  
Project Name/Number: 90000/90000

E-HSNF Policy/Contr Endorsemen Initial  
act/Fraternal t  
Certificate:  
Amendment,  
Insert  
Page,  
Endorsemen  
t or Rider

E-HSNF.pdf

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
Company Tracking Number: 90000 AR  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement  
Project Name/Number: 90000/90000

**Supporting Document Schedule Item Changes:**

**User Added -Name: Redlined Plan F Page 3**

Comment:

f\_ar page 3 redlined.pdf

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

**Amendment Letter**

Amendment Date:  
 Submitted Date: 06/23/2009

**Comments:**

Thank you for your approval of Heartland National Life Insurance Company's recent submission of our new Medicare Supplement policy forms 90000 A-G et al. (SERFF Tracking # ETPF-125992439, Arkansas Tracking # 41383) approved by the Arkansas Insurance Department on February 13, 2009. We appreciate your timely response.

In readying this product for market, we noticed two changes that needed to be made to the application form A-HNL-08 AR. We are submitting a revised application to address these changes. The changes are:

1. Page 1 – Payment Method:
  - a. Checkboxes have been added to allow the applicant to choose whether they want their bank draft to come from their checking or savings account.
  - b. The last paragraph has been amended.
    - i. It currently reads: Please include a voided check. The first draft will occur on the premium-due date after the policy has been issued. Subsequent drafts will occur on or shortly following the selected draft day requested above (never before).
    - ii. It has been amended to read: Please include a voided check.
2. Please note that since this was an approved form, we have changed the form number to A-HNL-09 AR.

We will continue to market this product using application form #A-HNL-08 AR until the revised form is approved. Attached please find both clean and redlined copies of the revised form. We look forward to hearing from you soon.

**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
A-HNL 09 AR	Application/EApplication - Initial enrollment Form	Application - Initial Medicare Supplement Insurance						A-HNL-09_ar app.pdf



SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

**Amendment Letter**

Amendment Date:  
 Submitted Date: 02/13/2009

**Comments:**

Attached is the 90000-F AR in place of the corrected 90000-G AR, which was attached in error.  
 Thanks again for your speedy review!  
 Jana Peterson  
 Senior Compliance Specialist

**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
90000-F AR	Policy/Contr	Medicare act/Fraternal Certificate	Initial					90000-f_ar.pdf

*SERFF Tracking Number:* ETPF-125992439      *State:* Arkansas  
*Filing Company:* Heartland National Life Insurance Company      *State Tracking Number:* 41383  
*Company Tracking Number:* 90000 AR  
*TOI:* MS051 Individual Medicare Supplement -      *Sub-TOI:* MS051.001 Plan A  
Standard Plans  
*Product Name:* Medicare Supplement  
*Project Name/Number:* 90000/90000

**Note To Filer**

**Created By:**

Stephanie Fowler on 02/13/2009 02:16 PM

**Last Edited By:**

Stephanie Fowler

**Submitted On:**

02/13/2009 02:16 PM

**Subject:**

Filing reopened

**Comments:**

Filing is reopened for correction.

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
Company Tracking Number: 90000 AR  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement  
Project Name/Number: 90000/90000

**Note To Reviewer**

**Created By:**

Jana Peterson on 02/13/2009 02:08 PM

**Last Edited By:**

Jana Peterson

**Submitted On:**

02/13/2009 02:08 PM

**Subject:**

Error

**Comments:**

Thanks for the quick approval - I just noticed that the revised 90000-F is really a 90000-G. Do you want to open this and let me send the correct policy?

Jana Peterson

Senior Compliance Specialist

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

## Form Schedule

Lead Form Number: 90020-A AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	90000-A AR	Policy/Cont ract/Fratern al Certificate	Medicare Supplement Policy Plan a	Initial			90000-a_ar.pdf
Approved	90000-D AR	Policy/Cont ract/Fratern al Certificate	Medicare Supplement Policy Plan D	Initial			90000-d_ar.pdf
Approved	90000-F AR	Policy/Cont ract/Fratern al Certificate	Medicare Supplement Policy Plan F	Initial			90000-f_ar.pdf
Approved	90000-G AR	Policy/Cont ract/Fratern al Certificate	Medicare Supplement Policy Plan G	Initial			90000-g_ar.pdf
Approved	A-HNL 09 AR	Application/ Enrollment Form	Application - Medicare Supplement Insurance	Initial			A-HNL-09_ar app.pdf
Approved	HNL-MQ-08	Application/ Enrollment Form	Medical Questions	Initial		0	HNL MQ-08.pdf
Approved	HRN-07	Other	Notice to Applicants Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage	Initial		0	HRN 07.pdf
Approved	OLC 90000	Outline of	Outline of Coverage	Initial			Olc90000-

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans

Product Name: Medicare Supplement

Project Name/Number: 90000/90000

	AR	Coverage			2009_ar.pdf
Approved	HPF-AR	Other Important Notice	Initial		HPF-AR.pdf
Approved	90000-F	Policy/Cont Page 3, Medicare	Initial		f_ar page
	AR p 3	ract/Fratern Supplement Policy			3.pdf
		al Plan F			
		Certificate			
Approved	E-HSNF	Policy/Cont Endorsement	Initial		E-HSNF.pdf
		ract/Fratern			
		al			
		Certificate:			
		Amendmen			
		t, Insert			
		Page,			
		Endorseme			
		nt or Rider			



**YOU HAVE SELECTED PLAN A. THIS POLICY PROVIDES BENEFITS WHICH SUPPLEMENT MEDICARE. IT IS GUARANTEED RENEWABLE FOR YOUR LIFETIME. WE HAVE THE RIGHT TO CHANGE PREMIUMS ONLY ON A CLASS BASIS BY STATE.**

**Medicare Supplement Policy** We Insure You, named as the Insured on the Policy Schedule. We promise to pay the benefits provided in this Policy for covered losses that are incurred while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached. **Notice to Buyer: This Policy may not cover all of Your medical expenses.**

**Your Thirty Day Right to Examine This Policy** If for any reason You are not satisfied with this Policy, You may return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all premiums You paid to Us and then You and We will be in the same position as if a Policy had never been issued.

**Coverage for Pre-existing Conditions** Benefits will be paid for all covered losses under this Policy, even those caused by a Sickness, Injury or physical condition that existed before the Effective Date of the Policy. Loss occurring during a Confinement is considered to commence with the first day of such Confinement.

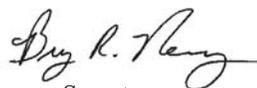
**Renewal Conditions** You may renew this Policy as long as You live. To renew, just pay a renewal premium. It must be paid on or before the end of the premium period, within the Grace Period, or during the Conservation Period. After this Policy is in force We cannot refuse to renew it or place any restrictions on it if the premium is paid on time.

**Premium Changes** We will not change the premiums for this Policy during Your first year of coverage within the 90000 Series. Thereafter, we can change them, but only if We change them for all policies like Yours in Your state on a class basis. A class is determined by benefits selected and year of issue. No rate adjustment may be made on an individual basis. Notice will be given to You at least 31 days before any premium change.

Your Policy benefits automatically change in accordance with Policy provisions whenever Medicare benefits change. After Your first year of coverage, the renewal premium for this Policy may change on a renewal date following the Effective Date of any change in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. Any such premium change will be based on the actuarial computations that We then use to determine the renewal premium.

**Consideration & Effective Date** This Policy is issued in consideration of the statements in Your application for insurance that is attached to and is made a part of this Policy, and the payment of the initial premium. This payment will keep the Policy in force until the first renewal date. The initial premium and the first renewal date are shown on Page 2. Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown on Page 2. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.

  
Secretary

  
President

**POLICY SCHEDULE**

Plan: Policy Number:  
Insured: Effective Date:  
First Renewal Date:  
Initial Premium:  
Endorsements:

**Renewal Premiums**

Annual                      Semi-Annual                      Quarterly                      Monthly Bank Draft

*You have selected Plan A, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

**61st to 90th Day  
Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.

**Lifetime  
Reserve  
Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.

**Following the  
Lifetime  
Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

**Part A & B  
Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

**Part B  
Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

*(This Page has been left blank intentionally.)*

## DEFINITIONS

*The person named as the "Insured" on Page 2 of this Policy is referred to in this Policy as You, Your, Yours, or Insured and Heartland National Life Insurance Company as We, Our or Us.*

<b>Benefit Period</b>	Means a period that begins, after the Effective Date of this Policy, with the first day of Hospital Confinement and ends at the close of 60 consecutive days during which You were not confined to a Hospital or skilled nursing facility.
<b>Coinsurance</b>	Means the difference between the Medicare approved amount and the Medicare payment after You have satisfied the applicable Medicare deductibles.
<b>Confinement</b>	Means medically required stay as a resident inpatient in a Hospital or skilled nursing facility. It must be on the specific recommendation and under the general supervision of a Doctor.
<b>Doctor</b>	Means a duly licensed person practicing in the healing arts and acting within the scope of that license in treating a Sickness or Injury. A Doctor must be other than an immediate member of Your family.
<b>Hospital</b>	Means a place that is licensed as a Hospital pursuant to law and is legally operated for the care and treatment of sick or injured persons at their expense. A Hospital does not include the following kinds of facilities (including units in a Hospital used for such care); (a) convalescent, nursing home, rest home, or nursing care facilities; (b) places that primarily treat the aged, drug addicts or alcoholics; and (c) facilities that primarily provide custodial or educational care.
<b>Injury</b>	Means bodily harm sustained by You which: (a) is the direct result of an accident or trauma that occurs while Your Policy is in force; and (b) is not related to Sickness, bodily infirmity or any other cause.
<b>Inpatient Hospital Deductible</b>	Means the initial Hospital expense incurred during a Benefit Period for which You are responsible under Medicare.
<b>Medicare</b>	Means Title XVIII of the United States Social Security Act of 1965, as then constituted or later amended.
<b>Medicare Part A</b>	Means the program under Medicare officially called "Hospital Insurance Benefit for the Aged and Disabled".
<b>Medicare Part B</b>	Means the program under Medicare officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled".
<b>Medicare Eligible Expenses</b>	Means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
<b>Sickness</b>	Means illness or disease of an insured person.

## LIMITATIONS & EXCLUSIONS

<b>Limitations &amp; Exclusions</b>	We will not pay benefits under this Policy for: <ul style="list-style-type: none"><li>a) Any expense which is not eligible for payment under Medicare, unless otherwise covered in Your Policy or by optional endorsement; or</li><li>b) Any expense which You are not legally obligated to pay.</li></ul>
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## ELIGIBILITY FOR COVERAGE

<b>Individual Not Covered by Medicare</b>	If You have not established entitlement to benefits under Medicare, We will provide benefits under this Policy as though You had established entitlement.
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## POLICY SUSPENSION

<b>Medicaid Entitlement</b>	<p>If You apply for and become entitled to medical assistance under Medicaid, the benefits and premiums under Your Policy will be suspended, if requested, for up to 24 months during Your Medicaid Entitlement. You must request this suspension within 90 days of becoming entitled to Medicaid.</p> <p>If You lose Your entitlement to Medicaid while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Medicaid Entitlement and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Medicaid Entitlement is terminated.</p>
<b>Group Health Plan Coverage</b>	<p>If You were eligible for, and purchased this Policy by reason of disability and You become covered under an employer or union based group health plan, Your benefits and premiums under this Policy will be suspended, if requested, while You are covered under the group health plan.</p> <p>If You lose coverage under Your group health plan while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Group Health Plan Coverage and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Group Health Plan Coverage is terminated.</p>
<b>Reinstitution</b>	<p>Your reinstated Policy will provide the same or substantially equivalent coverage that was in effect when your Policy was suspended. The premium for Your reinstated Policy will be on the same terms that would have applied had Your Policy not been suspended.</p>

## GENERAL PROVISIONS

<b>Entire Contract; Changes</b>	<p>This Policy with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.</p>
<b>Conformity with State Laws</b>	<p>Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that Effective Date is amended to conform to the minimum requirements of such laws.</p>
<b>Notice of Claim</b>	<p>Written Notice of Claim must be given within 6 months after a covered loss begins or as soon as possible. The notice can be given to Us at the address shown on Page 8, or to any one of Our agents. The notice should include Your name and Policy number.</p>
<b>Claim Forms</b>	<p>When We receive Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not sent to You within 15 days after giving such notice, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.</p>
<b>Electronic Claim Filing Process</b>	<p>Your health care providers will usually submit electronically to Medicare the billed charges for any medical or Hospital expenses You incur. Medicare then processes the benefits for expenses eligible under Part A and/or B, and then passes Your claim electronically to Us for consideration of benefits under Your Policy. We will accept Medicare's electronic submission of Your claim to Us as Your Notice of Claim and Your Claim Form. For consideration of expenses that are not submitted electronically to Us, a paper copy of Your Medicare Summary Notice can serve as Your Notice of Claim and Claim Form. The Medicare Summary Notice shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare Summary Notice to Us or Your health care provider may submit it to Us on Your behalf.</p>
<b>Proofs of Loss</b>	<p>Written Proof of Loss must be given to Us within 90 days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.</p>

<b>Payment of Benefits</b>	All benefits will be paid to You, or Your assignee. Benefits unpaid at Your death may be paid to Your estate or We may pay up to \$1,000 to any relative of Yours who is entitled to them. Any payment made in good faith will fully release Us to the extent of that payment.
<b>Timely Payment of Benefits</b>	Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.
<b>Assignment</b>	No assignment of benefits under this Policy shall be binding upon Us unless the original (or copy of it) is on file with Us. We do not assume any responsibility for the validity of any assignment.
<b>Other Insurance With Us</b>	Your insurance under a like policy or policies with Us is limited to one such policy elected by You, Your beneficiary or Your estate, as the case may be, and We will return all premiums paid for all such other policies.
<b>Grace Period</b>	This Policy has a 31 day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period this Policy will stay in force.
<b>Conservation Period</b>	We offer You an additional 15 days beyond the Grace Period to pay Your premium. During this 15 day extension, this Policy is not in force unless Your premium is paid within this period. The Policy will then be renewed with no lapse in coverage.
<b>Unpaid Premium</b>	We reserve the right to deduct any premium due and unpaid from a claim payment.
<b>Reinstatement</b>	<p>If the renewal premium is not paid before the Grace Period ends or within the Conservation Period, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for Reinstatement will Reinstatement this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be Reinstated as of the approval date. Lacking such approval this Policy will be Reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.</p> <p>The Reinstated Policy will only cover losses that result from Injury or Sickness sustained after the date of Reinstatement. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any premium accepted with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.</p>
<b>Continuation of Coverage</b>	We cannot terminate Your Policy as long as You pay Your premium on time. Termination of coverage under this Policy shall be without prejudice to any continuous loss for Confinement to a Hospital or skilled nursing facility that commences while this Policy is in force and during which You are determined to be continuously totally disabled. In this Policy, "continuously totally disabled" means the complete inability of a person to engage in all the normal activities of a person of the same age and gender.
<b>Refund of Unearned Premium</b>	We will refund that part of any premium paid which covers a period beyond the end of the Policy month of Your death.
<b>Time Limit on Certain Defenses</b>	No statements, except fraudulent misstatements, made by You in the application for this Policy, shall be used to void this Policy or to deny a claim for loss incurred after 2 years from the Effective Date of this Policy. No claim for loss occurring after the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition had existed before the Effective Date of this Policy.
<b>Legal Action</b>	No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years after the time written Proof of Loss is required to be given.

## YOUR MEDICARE SUPPLEMENT POLICY

If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.

If You have any questions about Your Policy, please write to Us and We will be happy to help You, or call Us, on Our toll free number listed above.

**Heartland National Life Insurance Company**  
**PO Box 2878**  
**Salt Lake City, Utah 84110-2878**

<p>Policy Benefits</p> <p>  Basic Benefits ..... Page 3</p> <p>    61st to 90th day</p> <p>    Lifetime Reserve</p> <p>    Following Lifetime Reserve</p> <p>    Part A &amp; B Blood</p> <p>    Part B Coinsurance</p> <p>  Additional Benefits (if any) ..... Page 3 &amp; 4</p> <p>Consideration ..... Page 1</p> <p>Coverage for Pre-existing Conditions ..... Page 1</p> <p>Definitions ..... Page 5</p> <p>  Benefit Period</p> <p>  Coinsurance</p> <p>  Confinement</p> <p>  Doctor</p> <p>  Hospital</p> <p>  Injury</p> <p>  Inpatient Hospital Deductible</p> <p>  Medicare</p> <p>  Medicare Part A</p> <p>  Medicare Part B</p> <p>  Medicare Eligible Expenses</p> <p>  Sickness</p> <p>Effective Date ..... Pages 1 &amp; 2</p>	<p>General Provisions ..... Pages 6 &amp; 7</p> <p>  Assignment</p> <p>  Claim Forms</p> <p>  Conformity with State Laws</p> <p>  Conservation Period</p> <p>  Continuation of Coverage</p> <p>  Electronic Claim Filing Process</p> <p>  Entire Contract; Changes</p> <p>  Grace Period</p> <p>  Legal Action</p> <p>  Misstatement of Age</p> <p>  Notice of Claim</p> <p>  Other Insurance with Us</p> <p>  Payment of Benefits</p> <p>  Proofs of Loss</p> <p>  Refund of Unearned Premium</p> <p>  Reinstatement</p> <p>  Time Limit on Certain Defenses</p> <p>  Timely Payment of Benefits</p> <p>  Unpaid Premium</p> <p>Individual Not Covered By Medicare ..... Page 5</p> <p>Limitations And Exclusions ..... Page 5</p> <p>Policy Suspension ..... Page 6</p> <p>Premium Changes ..... Page 1</p> <p>Renewal Conditions ..... Page 1</p> <p>Your Thirty Day Right to   Examine This Policy ..... Page 1</p>
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**YOU HAVE SELECTED PLAN D. THIS POLICY PROVIDES BENEFITS WHICH SUPPLEMENT MEDICARE. IT IS GUARANTEED RENEWABLE FOR YOUR LIFETIME. WE HAVE THE RIGHT TO CHANGE PREMIUMS ONLY ON A CLASS BASIS BY STATE.**

**Medicare Supplement Policy** We Insure You, named as the Insured on the Policy Schedule. We promise to pay the benefits provided in this Policy for covered losses that are incurred while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached. **Notice to Buyer: This Policy may not cover all of Your medical expenses.**

**Your Thirty Day Right to Examine This Policy** If for any reason You are not satisfied with this Policy, You may return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all premiums You paid to Us and then You and We will be in the same position as if a Policy had never been issued.

**Coverage for Pre-existing Conditions** Benefits will be paid for all covered losses under this Policy, even those caused by a Sickness, Injury or physical condition that existed before the Effective Date of the Policy. Loss occurring during a Confinement is considered to commence with the first day of such Confinement.

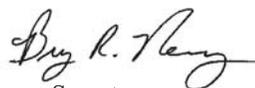
**Renewal Conditions** You may renew this Policy as long as You live. To renew, just pay a renewal premium. It must be paid on or before the end of the premium period, within the Grace Period, or during the Conservation Period. After this Policy is in force We cannot refuse to renew it or place any restrictions on it if the premium is paid on time.

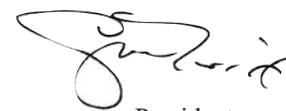
**Premium Changes** We will not change the premiums for this Policy during Your first year of coverage within the 90000 Series. Thereafter, we can change them, but only if We change them for all policies like Yours in Your state on a class basis. A class is determined by benefits selected and year of issue. No rate adjustment may be made on an individual basis. Notice will be given to You at least 31 days before any premium change.

Your Policy benefits automatically change in accordance with Policy provisions whenever Medicare benefits change. After Your first year of coverage, the renewal premium for this Policy may change on a renewal date following the Effective Date of any change in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. Any such premium change will be based on the actuarial computations that We then use to determine the renewal premium.

**Consideration & Effective Date** This Policy is issued in consideration of the statements in Your application for insurance that is attached to and is made a part of this Policy, and the payment of the initial premium. This payment will keep the Policy in force until the first renewal date. The initial premium and the first renewal date are shown on Page 2. Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown on Page 2. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.

  
Secretary

  
President

**POLICY SCHEDULE**

Plan: Policy Number:  
Insured: Effective Date:  
First Renewal Date:  
Initial Premium:  
Endorsements:

**Renewal Premiums**

Annual                      Semi-Annual                      Quarterly                      Monthly Bank Draft

*You have selected Plan D, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

- 61st to 90th Day Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.
- Lifetime Reserve Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.
- Following the Lifetime Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

- Part A & B Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

- Part B Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

## **ADDITIONAL BENEFITS**

- Medicare Part A Deductible** When You are confined as an inpatient to a Hospital, We will pay You the Medicare Part A Inpatient Hospital Deductible in any Medicare Benefit Period.
- Skilled Nursing Facility Benefit** We will pay You the actual billed charges up to the daily Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital skilled nursing facility care eligible under Medicare Part A.
- Medically Necessary Emergency Care in a Foreign Country** When You are traveling outside the United States and require Emergency Care, We will pay You 80% of the billed charges after a calendar year deductible of \$250. Emergency Care shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset beginning during the first 60 consecutive days of each trip outside the United States. Medical services must be of the type that Medicare would have covered if the care had been received in the United States. This benefit is subject to a lifetime maximum of \$50,000 dollars.

### ADDITIONAL BENEFITS (continued)

#### **At-Home Recovery Benefit**

We will pay You the actual charge, up to \$40 dollars per visit, for short term assistance with Activities of Daily Living furnished in Your Home by a Care Provider when you are recovering from a Sickness, Injury or surgery. You may receive up to 7 visits per week, with a calendar year maximum of 40 visits or \$1,600 dollars.

To receive benefits, Your Doctor must certify that the type and frequency of At-Home Recovery Visits are necessary because of a condition for which Your home care plan of treatment was approved by Medicare. All visits must be received during the period in which You are receiving Medicare approved home health care services, or within 8 weeks of the last date of service of a Medicare approved home health visit. In no event shall the total number of At-Home Recovery Visits exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

For purposes of this benefit, the following definitions shall apply:

(i) "Activities of Daily Living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings. (ii) "Care Provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry. (iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A Hospital or skilled nursing facility shall not be considered the insured's place of residence. (iv) "At-Home Recovery Visit" means the period of a visit required to provide At-Home Recovery Care, without limit on the duration of the visit, except each consecutive 4 hours in a 24 hour period of services provided by a Care Provider is one visit.

Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government program; and (ii) care provided by family members, unpaid volunteers or providers who are not Care Providers.

## DEFINITIONS

*The person named as the "Insured" on Page 2 of this Policy is referred to in this Policy as You, Your, Yours, or Insured and Heartland National Life Insurance Company as We, Our or Us.*

<b>Benefit Period</b>	Means a period that begins, after the Effective Date of this Policy, with the first day of Hospital Confinement and ends at the close of 60 consecutive days during which You were not confined to a Hospital or skilled nursing facility.
<b>Coinsurance</b>	Means the difference between the Medicare approved amount and the Medicare payment after You have satisfied the applicable Medicare deductibles.
<b>Confinement</b>	Means medically required stay as a resident inpatient in a Hospital or skilled nursing facility. It must be on the specific recommendation and under the general supervision of a Doctor.
<b>Doctor</b>	Means a duly licensed person practicing in the healing arts and acting within the scope of that license in treating a Sickness or Injury. A Doctor must be other than an immediate member of Your family.
<b>Hospital</b>	Means a place that is licensed as a Hospital pursuant to law and is legally operated for the care and treatment of sick or injured persons at their expense. A Hospital does not include the following kinds of facilities (including units in a Hospital used for such care); (a) convalescent, nursing home, rest home, or nursing care facilities; (b) places that primarily treat the aged, drug addicts or alcoholics; and (c) facilities that primarily provide custodial or educational care.
<b>Injury</b>	Means bodily harm sustained by You which: (a) is the direct result of an accident or trauma that occurs while Your Policy is in force; and (b) is not related to Sickness, bodily infirmity or any other cause.
<b>Inpatient Hospital Deductible</b>	Means the initial Hospital expense incurred during a Benefit Period for which You are responsible under Medicare.
<b>Medicare</b>	Means Title XVIII of the United States Social Security Act of 1965, as then constituted or later amended.
<b>Medicare Part A</b>	Means the program under Medicare officially called "Hospital Insurance Benefit for the Aged and Disabled".
<b>Medicare Part B</b>	Means the program under Medicare officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled".
<b>Medicare Eligible Expenses</b>	Means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
<b>Sickness</b>	Means illness or disease of an insured person.

## LIMITATIONS & EXCLUSIONS

<b>Limitations &amp; Exclusions</b>	We will not pay benefits under this Policy for: <ul style="list-style-type: none"><li>a) Any expense which is not eligible for payment under Medicare, unless otherwise covered in Your Policy or by optional endorsement; or</li><li>b) Any expense which You are not legally obligated to pay.</li></ul>
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## ELIGIBILITY FOR COVERAGE

<b>Individual Not Covered by Medicare</b>	If You have not established entitlement to benefits under Medicare, We will provide benefits under this Policy as though You had established entitlement.
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## POLICY SUSPENSION

<b>Medicaid Entitlement</b>	<p>If You apply for and become entitled to medical assistance under Medicaid, the benefits and premiums under Your Policy will be suspended, if requested, for up to 24 months during Your Medicaid Entitlement. You must request this suspension within 90 days of becoming entitled to Medicaid.</p> <p>If You lose Your entitlement to Medicaid while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Medicaid Entitlement and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Medicaid Entitlement is terminated.</p>
<b>Group Health Plan Coverage</b>	<p>If You were eligible for, and purchased this Policy by reason of disability and You become covered under an employer or union based group health plan, Your benefits and premiums under this Policy will be suspended, if requested, while You are covered under the group health plan.</p> <p>If You lose coverage under Your group health plan while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Group Health Plan Coverage and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Group Health Plan Coverage is terminated.</p>
<b>Reinstitution</b>	<p>Your reinstated Policy will provide the same or substantially equivalent coverage that was in effect when your Policy was suspended. The premium for Your reinstated Policy will be on the same terms that would have applied had Your Policy not been suspended.</p>

## GENERAL PROVISIONS

<b>Entire Contract; Changes</b>	<p>This Policy with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.</p>
<b>Conformity with State Laws</b>	<p>Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that Effective Date is amended to conform to the minimum requirements of such laws.</p>
<b>Notice of Claim</b>	<p>Written Notice of Claim must be given within 6 months after a covered loss begins or as soon as possible. The notice can be given to Us at the address shown on Page 8, or to any one of Our agents. The notice should include Your name and Policy number.</p>
<b>Claim Forms</b>	<p>When We receive Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not sent to You within 15 days after giving such notice, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.</p>
<b>Electronic Claim Filing Process</b>	<p>Your health care providers will usually submit electronically to Medicare the billed charges for any medical or Hospital expenses You incur. Medicare then processes the benefits for expenses eligible under Part A and/or B, and then passes Your claim electronically to Us for consideration of benefits under Your Policy. We will accept Medicare's electronic submission of Your claim to Us as Your Notice of Claim and Your Claim Form. For consideration of expenses that are not submitted electronically to Us, a paper copy of Your Medicare Summary Notice can serve as Your Notice of Claim and Claim Form. The Medicare Summary Notice shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare Summary Notice to Us or Your health care provider may submit it to Us on Your behalf.</p>
<b>Proofs of Loss</b>	<p>Written Proof of Loss must be given to Us within 90 days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.</p>

<b>Payment of Benefits</b>	All benefits will be paid to You, or Your assignee. Benefits unpaid at Your death may be paid to Your estate or We may pay up to \$1,000 to any relative of Yours who is entitled to them. Any payment made in good faith will fully release Us to the extent of that payment.
<b>Timely Payment of Benefits</b>	Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.
<b>Assignment</b>	No assignment of benefits under this Policy shall be binding upon Us unless the original (or copy of it) is on file with Us. We do not assume any responsibility for the validity of any assignment.
<b>Other Insurance With Us</b>	Your insurance under a like policy or policies with Us is limited to one such policy elected by You, Your beneficiary or Your estate, as the case may be, and We will return all premiums paid for all such other policies.
<b>Grace Period</b>	This Policy has a 31 day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period this Policy will stay in force.
<b>Conservation Period</b>	We offer You an additional 15 days beyond the Grace Period to pay Your premium. During this 15 day extension, this Policy is not in force unless Your premium is paid within this period. The Policy will then be renewed with no lapse in coverage.
<b>Unpaid Premium</b>	We reserve the right to deduct any premium due and unpaid from a claim payment.
<b>Reinstatement</b>	<p>If the renewal premium is not paid before the Grace Period ends or within the Conservation Period, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for Reinstatement will Reinstatement this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be Reinstated as of the approval date. Lacking such approval this Policy will be Reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.</p> <p>The Reinstated Policy will only cover losses that result from Injury or Sickness sustained after the date of Reinstatement. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any premium accepted with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.</p>
<b>Continuation of Coverage</b>	We cannot terminate Your Policy as long as You pay Your premium on time. Termination of coverage under this Policy shall be without prejudice to any continuous loss for Confinement to a Hospital or skilled nursing facility that commences while this Policy is in force and during which You are determined to be continuously totally disabled. In this Policy, "continuously totally disabled" means the complete inability of a person to engage in all the normal activities of a person of the same age and gender.
<b>Refund of Unearned Premium</b>	We will refund that part of any premium paid which covers a period beyond the end of the Policy month of Your death.
<b>Time Limit on Certain Defenses</b>	No statements, except fraudulent misstatements, made by You in the application for this Policy, shall be used to void this Policy or to deny a claim for loss incurred after 2 years from the Effective Date of this Policy. No claim for loss occurring after the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition had existed before the Effective Date of this Policy.
<b>Legal Action</b>	No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years after the time written Proof of Loss is required to be given.

**YOUR MEDICARE SUPPLEMENT POLICY**

If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.

If You have any questions about Your Policy, please write to Us and We will be happy to help You, or call Us, on Our toll free number listed above.

**Heartland National Life Insurance Company**  
**PO Box 2878**  
**Salt Lake City, Utah 84110-2878**

<p>Policy Benefits</p> <p>    Basic Benefits . . . . . Page 3</p> <p>        61st to 90th day</p> <p>        Lifetime Reserve</p> <p>        Following Lifetime Reserve</p> <p>        Part A &amp; B Blood</p> <p>        Part B Coinsurance</p> <p>    Additional Benefits (if any) . . . . . Page 3 &amp; 4</p> <p>Consideration . . . . . Page 1</p> <p>Coverage for Pre-existing Conditions . . . . . Page 1</p> <p>Definitions . . . . . Page 5</p> <p>    Benefit Period</p> <p>    Coinsurance</p> <p>    Confinement</p> <p>    Doctor</p> <p>    Hospital</p> <p>    Injury</p> <p>    Inpatient Hospital Deductible</p> <p>    Medicare</p> <p>    Medicare Part A</p> <p>    Medicare Part B</p> <p>    Medicare Eligible Expenses</p> <p>    Sickness</p> <p>Effective Date . . . . . Pages 1 &amp; 2</p>	<p>General Provisions . . . . . Pages 6 &amp; 7</p> <p>    Assignment</p> <p>    Claim Forms</p> <p>    Conformity with State Laws</p> <p>    Conservation Period</p> <p>    Continuation of Coverage</p> <p>    Electronic Claim Filing Process</p> <p>    Entire Contract; Changes</p> <p>    Grace Period</p> <p>    Legal Action</p> <p>    Misstatement of Age</p> <p>    Notice of Claim</p> <p>    Other Insurance with Us</p> <p>    Payment of Benefits</p> <p>    Proofs of Loss</p> <p>    Refund of Unearned Premium</p> <p>    Reinstatement</p> <p>    Time Limit on Certain Defenses</p> <p>    Timely Payment of Benefits</p> <p>    Unpaid Premium</p> <p>Individual Not Covered By Medicare . . . . . Page 5</p> <p>Limitations And Exclusions . . . . . Page 5</p> <p>Policy Suspension . . . . . Page 6</p> <p>Premium Changes . . . . . Page 1</p> <p>Renewal Conditions . . . . . Page 1</p> <p>Your Thirty Day Right to     Examine This Policy . . . . . Page 1</p>
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**YOU HAVE SELECTED PLAN F. THIS POLICY PROVIDES BENEFITS WHICH SUPPLEMENT MEDICARE. IT IS GUARANTEED RENEWABLE FOR YOUR LIFETIME. WE HAVE THE RIGHT TO CHANGE PREMIUMS ONLY ON A CLASS BASIS BY STATE.**

**Medicare Supplement Policy** We Insure You, named as the Insured on the Policy Schedule. We promise to pay the benefits provided in this Policy for covered losses that are incurred while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached. **Notice to Buyer: This Policy may not cover all of Your medical expenses.**

**Your Thirty Day Right to Examine This Policy** If for any reason You are not satisfied with this Policy, You may return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all premiums You paid to Us and then You and We will be in the same position as if a Policy had never been issued.

**Coverage for Pre-existing Conditions** Benefits will be paid for all covered losses under this Policy, even those caused by a Sickness, Injury or physical condition that existed before the Effective Date of the Policy. Loss occurring during a Confinement is considered to commence with the first day of such Confinement.

**Renewal Conditions** You may renew this Policy as long as You live. To renew, just pay a renewal premium. It must be paid on or before the end of the premium period, within the Grace Period, or during the Conservation Period. After this Policy is in force We cannot refuse to renew it or place any restrictions on it if the premium is paid on time.

**Premium Changes** We will not change the premiums for this Policy during Your first year of coverage within the {90000} Series. Thereafter, we can change them, but only if We change them for all policies like Yours in Your state on a class basis. A class is determined by benefits selected and year of issue. No rate adjustment may be made on an individual basis. Notice will be given to You at least 31 days before any premium change.

Your Policy benefits automatically change in accordance with Policy provisions whenever Medicare benefits change. After Your first year of coverage, the renewal premium for this Policy may change on a renewal date following the Effective Date of any change in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. Any such premium change will be based on the actuarial computations that We then use to determine the renewal premium.

**Consideration & Effective Date** This Policy is issued in consideration of the statements in Your application for insurance that is attached to and is made a part of this Policy, and the payment of the initial premium. This payment will keep the Policy in force until the first renewal date. The initial premium and the first renewal date are shown on Page 2. Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown on Page 2. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.

  
Secretary

  
President

**POLICY SCHEDULE**

Plan: Policy Number:  
Insured: Effective Date:  
First Renewal Date:  
Initial Premium:  
Endorsements:

**Renewal Premiums**

Annual                      Semi-Annual                      Quarterly                      Monthly Bank Draft

*You have selected Plan F, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

- 61st to 90th Day Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.
- Lifetime Reserve Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.
- Following the Lifetime Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

- Part A & B Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

- Part B Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

## **ADDITIONAL BENEFITS**

- Medicare Part A Deductible** When You are confined as an inpatient to a Hospital, We will pay You the Medicare Part A Inpatient Hospital Deductible in any Medicare Benefit Period.
- Medicare Part B Deductible** We will pay You for all Eligible Expenses used to satisfy Your Medicare Part B deductible amount per calendar year regardless of Hospital Confinement.
- 100% of the Medicare Part B Excess Charges** We will pay You 100% of the difference between the actual Medicare Part B billed charge, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.
- Medically Necessary Emergency Care in a Foreign Country** When You are traveling outside the United States and require Emergency Care, we will pay You 80% of the billed charges after a calendar year deductible of \$250. Emergency Care shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset beginning during the first 60 consecutive days of each trip outside the United States. Medical services must be of the type that Medicare would have covered if the care had been received in the United States. This benefit is subject to a lifetime maximum of \$50,000 dollars.

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## DEFINITIONS

*The person named as the "Insured" on Page 2 of this Policy is referred to in this Policy as You, Your, Yours, or Insured and Heartland National Life Insurance Company as We, Our or Us.*

<b>Benefit Period</b>	Means a period that begins, after the Effective Date of this Policy, with the first day of Hospital Confinement and ends at the close of 60 consecutive days during which You were not confined to a Hospital or skilled nursing facility.
<b>Coinsurance</b>	Means the difference between the Medicare approved amount and the Medicare payment after You have satisfied the applicable Medicare deductibles.
<b>Confinement</b>	Means medically required stay as a resident inpatient in a Hospital or skilled nursing facility. It must be on the specific recommendation and under the general supervision of a Doctor.
<b>Doctor</b>	Means a duly licensed person practicing in the healing arts and acting within the scope of that license in treating a Sickness or Injury. A Doctor must be other than an immediate member of Your family.
<b>Hospital</b>	Means a place that is licensed as a Hospital pursuant to law and is legally operated for the care and treatment of sick or injured persons at their expense. A Hospital does not include the following kinds of facilities (including units in a Hospital used for such care); (a) convalescent, nursing home, rest home, or nursing care facilities; (b) places that primarily treat the aged, drug addicts or alcoholics; and (c) facilities that primarily provide custodial or educational care.
<b>Injury</b>	Means bodily harm sustained by You which: (a) is the direct result of an accident or trauma that occurs while Your Policy is in force; and (b) is not related to Sickness, bodily infirmity or any other cause.
<b>Inpatient Hospital Deductible</b>	Means the initial Hospital expense incurred during a Benefit Period for which You are responsible under Medicare.
<b>Medicare</b>	Means Title XVIII of the United States Social Security Act of 1965, as then constituted or later amended.
<b>Medicare Part A</b>	Means the program under Medicare officially called "Hospital Insurance Benefit for the Aged and Disabled".
<b>Medicare Part B</b>	Means the program under Medicare officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled".
<b>Medicare Eligible Expenses</b>	Means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
<b>Sickness</b>	Means illness or disease of an insured person.

## LIMITATIONS & EXCLUSIONS

<b>Limitations &amp; Exclusions</b>	We will not pay benefits under this Policy for: <ul style="list-style-type: none"><li>a) Any expense which is not eligible for payment under Medicare, unless otherwise covered in Your Policy or by optional endorsement; or</li><li>b) Any expense which You are not legally obligated to pay.</li></ul>
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## ELIGIBILITY FOR COVERAGE

<b>Individual Not Covered by Medicare</b>	If You have not established entitlement to benefits under Medicare, We will provide benefits under this Policy as though You had established entitlement.
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## POLICY SUSPENSION

<b>Medicaid Entitlement</b>	<p>If You apply for and become entitled to medical assistance under Medicaid, the benefits and premiums under Your Policy will be suspended, if requested, for up to 24 months during Your Medicaid Entitlement. You must request this suspension within 90 days of becoming entitled to Medicaid.</p> <p>If You lose Your entitlement to Medicaid while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Medicaid Entitlement and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Medicaid Entitlement is terminated.</p>
<b>Group Health Plan Coverage</b>	<p>If You were eligible for, and purchased this Policy by reason of disability and You become covered under an employer or union based group health plan, Your benefits and premiums under this Policy will be suspended, if requested, while You are covered under the group health plan.</p> <p>If You lose coverage under Your group health plan while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Group Health Plan Coverage and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Group Health Plan Coverage is terminated.</p>
<b>Reinstitution</b>	<p>Your reinstated Policy will provide the same or substantially equivalent coverage that was in effect when your Policy was suspended. The premium for Your reinstated Policy will be on the same terms that would have applied had Your Policy not been suspended.</p>

## GENERAL PROVISIONS

<b>Entire Contract; Changes</b>	<p>This Policy with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.</p>
<b>Conformity with State Laws</b>	<p>Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that Effective Date is amended to conform to the minimum requirements of such laws.</p>
<b>Notice of Claim</b>	<p>Written Notice of Claim must be given within 6 months after a covered loss begins or as soon as possible. The notice can be given to Us at the address shown on Page 8, or to any one of Our agents. The notice should include Your name and Policy number.</p>
<b>Claim Forms</b>	<p>When We receive Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not sent to You within 15 days after giving such notice, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.</p>
<b>Electronic Claim Filing Process</b>	<p>Your health care providers will usually submit electronically to Medicare the billed charges for any medical or Hospital expenses You incur. Medicare then processes the benefits for expenses eligible under Part A and/or B, and then passes Your claim electronically to Us for consideration of benefits under Your Policy. We will accept Medicare's electronic submission of Your claim to Us as Your Notice of Claim and Your Claim Form. For consideration of expenses that are not submitted electronically to Us, a paper copy of Your Medicare Summary Notice can serve as Your Notice of Claim and Claim Form. The Medicare Summary Notice shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare Summary Notice to Us or Your health care provider may submit it to Us on Your behalf.</p>
<b>Proofs of Loss</b>	<p>Written Proof of Loss must be given to Us within 90 days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.</p>

<b>Payment of Benefits</b>	All benefits will be paid to You, or Your assignee. Benefits unpaid at Your death may be paid to Your estate or We may pay up to \$1,000 to any relative of Yours who is entitled to them. Any payment made in good faith will fully release Us to the extent of that payment.
<b>Timely Payment of Benefits</b>	Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.
<b>Assignment</b>	No assignment of benefits under this Policy shall be binding upon Us unless the original (or copy of it) is on file with Us. We do not assume any responsibility for the validity of any assignment.
<b>Other Insurance With Us</b>	Your insurance under a like policy or policies with Us is limited to one such policy elected by You, Your beneficiary or Your estate, as the case may be, and We will return all premiums paid for all such other policies.
<b>Grace Period</b>	This Policy has a 31 day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period this Policy will stay in force.
<b>Conservation Period</b>	We offer You an additional 15 days beyond the Grace Period to pay Your premium. During this 15 day extension, this Policy is not in force unless Your premium is paid within this period. The Policy will then be renewed with no lapse in coverage.
<b>Unpaid Premium</b>	We reserve the right to deduct any premium due and unpaid from a claim payment.
<b>Reinstatement</b>	<p>If the renewal premium is not paid before the Grace Period ends or within the Conservation Period, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for Reinstatement will Reinstatement this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be Reinstated as of the approval date. Lacking such approval this Policy will be Reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.</p> <p>The Reinstated Policy will only cover losses that result from Injury or Sickness sustained after the date of Reinstatement. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any premium accepted with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.</p>
<b>Continuation of Coverage</b>	We cannot terminate Your Policy as long as You pay Your premium on time. Termination of coverage under this Policy shall be without prejudice to any continuous loss for Confinement to a Hospital or skilled nursing facility that commences while this Policy is in force and during which You are determined to be continuously totally disabled. In this Policy, "continuously totally disabled" means the complete inability of a person to engage in all the normal activities of a person of the same age and gender.
<b>Refund of Unearned Premium</b>	We will refund that part of any premium paid which covers a period beyond the end of the Policy month of Your death.
<b>Time Limit on Certain Defenses</b>	No statements, except fraudulent misstatements, made by You in the application for this Policy, shall be used to void this Policy or to deny a claim for loss incurred after 2 years from the Effective Date of this Policy. No claim for loss occurring after the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition had existed before the Effective Date of this Policy.
<b>Legal Action</b>	No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years after the time written Proof of Loss is required to be given.

**YOUR MEDICARE SUPPLEMENT POLICY**

If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.

If You have any questions about Your Policy, please write to Us and We will be happy to help You, or call Us, on Our toll free number listed above.

**Heartland National Life Insurance Company**  
**PO Box 2878**  
**Salt Lake City, Utah 84110-2878**

<p>Policy Benefits</p> <p style="padding-left: 20px;">Basic Benefits . . . . . Page 3</p> <p style="padding-left: 40px;">61st to 90th day</p> <p style="padding-left: 40px;">Lifetime Reserve</p> <p style="padding-left: 40px;">Following Lifetime Reserve</p> <p style="padding-left: 40px;">Part A &amp; B Blood</p> <p style="padding-left: 40px;">Part B Coinsurance</p> <p style="padding-left: 20px;">Additional Benefits (if any) . . . . . Page 3 &amp; 4</p> <p>Consideration . . . . . Page 1</p> <p>Coverage for Pre-existing Conditions . . . . . Page 1</p> <p>Definitions . . . . . Page 5</p> <p style="padding-left: 20px;">Benefit Period</p> <p style="padding-left: 20px;">Coinsurance</p> <p style="padding-left: 20px;">Confinement</p> <p style="padding-left: 20px;">Doctor</p> <p style="padding-left: 20px;">Hospital</p> <p style="padding-left: 20px;">Injury</p> <p style="padding-left: 20px;">Inpatient Hospital Deductible</p> <p style="padding-left: 20px;">Medicare</p> <p style="padding-left: 20px;">Medicare Part A</p> <p style="padding-left: 20px;">Medicare Part B</p> <p style="padding-left: 20px;">Medicare Eligible Expenses</p> <p style="padding-left: 20px;">Sickness</p> <p>Effective Date . . . . . Pages 1 &amp; 2</p>	<p>General Provisions . . . . . Pages 6 &amp; 7</p> <p style="padding-left: 20px;">Assignment</p> <p style="padding-left: 20px;">Claim Forms</p> <p style="padding-left: 20px;">Conformity with State Laws</p> <p style="padding-left: 20px;">Conservation Period</p> <p style="padding-left: 20px;">Continuation of Coverage</p> <p style="padding-left: 20px;">Electronic Claim Filing Process</p> <p style="padding-left: 20px;">Entire Contract; Changes</p> <p style="padding-left: 20px;">Grace Period</p> <p style="padding-left: 20px;">Legal Action</p> <p style="padding-left: 20px;">Misstatement of Age</p> <p style="padding-left: 20px;">Notice of Claim</p> <p style="padding-left: 20px;">Other Insurance with Us</p> <p style="padding-left: 20px;">Payment of Benefits</p> <p style="padding-left: 20px;">Proofs of Loss</p> <p style="padding-left: 20px;">Refund of Unearned Premium</p> <p style="padding-left: 20px;">Reinstatement</p> <p style="padding-left: 20px;">Time Limit on Certain Defenses</p> <p style="padding-left: 20px;">Timely Payment of Benefits</p> <p style="padding-left: 20px;">Unpaid Premium</p> <p>Individual Not Covered By Medicare . . . . . Page 5</p> <p>Limitations And Exclusions . . . . . Page 5</p> <p>Policy Suspension . . . . . Page 6</p> <p>Premium Changes . . . . . Page 1</p> <p>Renewal Conditions . . . . . Page 1</p> <p>Your Thirty Day Right to Examine This Policy . . . . . Page 1</p>
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**YOU HAVE SELECTED PLAN G. THIS POLICY PROVIDES BENEFITS WHICH SUPPLEMENT MEDICARE. IT IS GUARANTEED RENEWABLE FOR YOUR LIFETIME. WE HAVE THE RIGHT TO CHANGE PREMIUMS ONLY ON A CLASS BASIS BY STATE.**

**Medicare Supplement Policy** We Insure You, named as the Insured on the Policy Schedule. We promise to pay the benefits provided in this Policy for covered losses that are incurred while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached. **Notice to Buyer: This Policy may not cover all of Your medical expenses.**

**Your Thirty Day Right to Examine This Policy** If for any reason You are not satisfied with this Policy, You may return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all premiums You paid to Us and then You and We will be in the same position as if a Policy had never been issued.

**Coverage for Pre-existing Conditions** Benefits will be paid for all covered losses under this Policy, even those caused by a Sickness, Injury or physical condition that existed before the Effective Date of the Policy. Loss occurring during a Confinement is considered to commence with the first day of such Confinement.

**Renewal Conditions** You may renew this Policy as long as You live. To renew, just pay a renewal premium. It must be paid on or before the end of the premium period, within the Grace Period, or during the Conservation Period. After this Policy is in force We cannot refuse to renew it or place any restrictions on it if the premium is paid on time.

**Premium Changes** We will not change the premiums for this Policy during Your first year of coverage within the 90000 Series. Thereafter, we can change them, but only if We change them for all policies like Yours in Your state on a class basis. A class is determined by benefits selected and year of issue. No rate adjustment may be made on an individual basis. Notice will be given to You at least 31 days before any premium change.

Your Policy benefits automatically change in accordance with Policy provisions whenever Medicare benefits change. After Your first year of coverage, the renewal premium for this Policy may change on a renewal date following the Effective Date of any change in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. Any such premium change will be based on the actuarial computations that We then use to determine the renewal premium.

**Consideration & Effective Date** This Policy is issued in consideration of the statements in Your application for insurance that is attached to and is made a part of this Policy, and the payment of the initial premium. This payment will keep the Policy in force until the first renewal date. The initial premium and the first renewal date are shown on Page 2. Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown on Page 2. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.

  
Secretary

  
President

**POLICY SCHEDULE**

Plan: Policy Number:  
Insured: Effective Date:  
First Renewal Date:  
Initial Premium:  
Endorsements:

**Renewal Premiums**

Annual                      Semi-Annual                      Quarterly                      Monthly Bank Draft

*You have selected Plan G, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

- 61st to 90th Day Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.
- Lifetime Reserve Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.
- Following the Lifetime Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

- Part A & B Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

- Part B Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

## **ADDITIONAL BENEFITS**

- Medicare Part A Deductible** When You are confined as an inpatient to a Hospital, We will pay You the Medicare Part A Inpatient Hospital Deductible in any Medicare Benefit Period.
- Skilled Nursing Facility Benefit** We will pay You the actual billed charges up to the daily Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital skilled nursing facility care eligible under Medicare Part A.
- 80% of the Medicare Part B Excess Charges** We will pay You 80% of the difference between the actual Medicare Part B billed charge, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.
- Medically Necessary Emergency Care in a Foreign Country** When You are traveling outside the United States and require Emergency Care, we will pay You 80% of the billed charges after a calendar year deductible of \$250. Emergency Care shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset beginning during the first 60 consecutive days of each trip outside the United States. Medical services must be of the type that Medicare would have covered if the care had been received in the United States. This benefit is subject to a lifetime maximum of \$50,000 dollars.

**Benefits are continued on Page 4**

### ADDITIONAL BENEFITS (continued)

#### **At-Home Recovery Benefit**

We will pay You the actual charge, up to \$40 dollars per visit, for short term assistance with Activities of Daily Living furnished in Your Home by a Care Provider when you are recovering from a Sickness, Injury or surgery. You may receive up to 7 visits per week, with a calendar year maximum of 40 visits or \$1,600 dollars.

To receive benefits, Your Doctor must certify that the type and frequency of At-Home Recovery Visits are necessary because of a condition for which Your home care plan of treatment was approved by Medicare. All visits must be received during the period in which You are receiving Medicare approved home health care services, or within 8 weeks of the last date of service of a Medicare approved home health visit. In no event shall the total number of At-Home Recovery Visits exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

For purposes of this benefit, the following definitions shall apply:

(i) "Activities of Daily Living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings. (ii) "Care Provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry. (iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A Hospital or skilled nursing facility shall not be considered the insured's place of residence. (iv) "At-Home Recovery Visit" means the period of a visit required to provide At-Home Recovery Care, without limit on the duration of the visit, except each consecutive 4 hours in a 24 hour period of services provided by a Care Provider is one visit.

Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and (ii) care provided by family members, unpaid volunteers or providers who are not Care Providers.

## DEFINITIONS

*The person named as the "Insured" on Page 2 of this Policy is referred to in this Policy as You, Your, Yours, or Insured and Heartland National Life Insurance Company as We, Our or Us.*

<b>Benefit Period</b>	Means a period that begins, after the Effective Date of this Policy, with the first day of Hospital Confinement and ends at the close of 60 consecutive days during which You were not confined to a Hospital or skilled nursing facility.
<b>Coinsurance</b>	Means the difference between the Medicare approved amount and the Medicare payment after You have satisfied the applicable Medicare deductibles.
<b>Confinement</b>	Means medically required stay as a resident inpatient in a Hospital or skilled nursing facility. It must be on the specific recommendation and under the general supervision of a Doctor.
<b>Doctor</b>	Means a duly licensed person practicing in the healing arts and acting within the scope of that license in treating a Sickness or Injury. A Doctor must be other than an immediate member of Your family.
<b>Hospital</b>	Means a place that is licensed as a Hospital pursuant to law and is legally operated for the care and treatment of sick or injured persons at their expense. A Hospital does not include the following kinds of facilities (including units in a Hospital used for such care); (a) convalescent, nursing home, rest home, or nursing care facilities; (b) places that primarily treat the aged, drug addicts or alcoholics; and (c) facilities that primarily provide custodial or educational care.
<b>Injury</b>	Means bodily harm sustained by You which: (a) is the direct result of an accident or trauma that occurs while Your Policy is in force; and (b) is not related to Sickness, bodily infirmity or any other cause.
<b>Inpatient Hospital Deductible</b>	Means the initial Hospital expense incurred during a Benefit Period for which You are responsible under Medicare.
<b>Medicare</b>	Means Title XVIII of the United States Social Security Act of 1965, as then constituted or later amended.
<b>Medicare Part A</b>	Means the program under Medicare officially called "Hospital Insurance Benefit for the Aged and Disabled".
<b>Medicare Part B</b>	Means the program under Medicare officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled".
<b>Medicare Eligible Expenses</b>	Means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
<b>Sickness</b>	Means illness or disease of an insured person.

## LIMITATIONS & EXCLUSIONS

<b>Limitations &amp; Exclusions</b>	We will not pay benefits under this Policy for: <ul style="list-style-type: none"><li>a) Any expense which is not eligible for payment under Medicare, unless otherwise covered in Your Policy or by optional endorsement; or</li><li>b) Any expense which You are not legally obligated to pay.</li></ul>
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## ELIGIBILITY FOR COVERAGE

<b>Individual Not Covered by Medicare</b>	If You have not established entitlement to benefits under Medicare, We will provide benefits under this Policy as though You had established entitlement.
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## POLICY SUSPENSION

<b>Medicaid Entitlement</b>	<p>If You apply for and become entitled to medical assistance under Medicaid, the benefits and premiums under Your Policy will be suspended, if requested, for up to 24 months during Your Medicaid Entitlement. You must request this suspension within 90 days of becoming entitled to Medicaid.</p> <p>If You lose Your entitlement to Medicaid while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Medicaid Entitlement and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Medicaid Entitlement is terminated.</p>
<b>Group Health Plan Coverage</b>	<p>If You were eligible for, and purchased this Policy by reason of disability and You become covered under an employer or union based group health plan, Your benefits and premiums under this Policy will be suspended, if requested, while You are covered under the group health plan.</p> <p>If You lose coverage under Your group health plan while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Group Health Plan Coverage and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Group Health Plan Coverage is terminated.</p>
<b>Reinstitution</b>	<p>Your reinstated Policy will provide the same or substantially equivalent coverage that was in effect when your Policy was suspended. The premium for Your reinstated Policy will be on the same terms that would have applied had Your Policy not been suspended.</p>

## GENERAL PROVISIONS

<b>Entire Contract; Changes</b>	<p>This Policy with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.</p>
<b>Conformity with State Laws</b>	<p>Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that Effective Date is amended to conform to the minimum requirements of such laws.</p>
<b>Notice of Claim</b>	<p>Written Notice of Claim must be given within 6 months after a covered loss begins or as soon as possible. The notice can be given to Us at the address shown on Page 8, or to any one of Our agents. The notice should include Your name and Policy number.</p>
<b>Claim Forms</b>	<p>When We receive Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not sent to You within 15 days after giving such notice, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.</p>
<b>Electronic Claim Filing Process</b>	<p>Your health care providers will usually submit electronically to Medicare the billed charges for any medical or Hospital expenses You incur. Medicare then processes the benefits for expenses eligible under Part A and/or B, and then passes Your claim electronically to Us for consideration of benefits under Your Policy. We will accept Medicare's electronic submission of Your claim to Us as Your Notice of Claim and Your Claim Form. For consideration of expenses that are not submitted electronically to Us, a paper copy of Your Medicare Summary Notice can serve as Your Notice of Claim and Claim Form. The Medicare Summary Notice shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare Summary Notice to Us or Your health care provider may submit it to Us on Your behalf.</p>
<b>Proofs of Loss</b>	<p>Written Proof of Loss must be given to Us within 90 days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.</p>

<b>Payment of Benefits</b>	All benefits will be paid to You, or Your assignee. Benefits unpaid at Your death may be paid to Your estate or We may pay up to \$1,000 to any relative of Yours who is entitled to them. Any payment made in good faith will fully release Us to the extent of that payment.
<b>Timely Payment of Benefits</b>	Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.
<b>Assignment</b>	No assignment of benefits under this Policy shall be binding upon Us unless the original (or copy of it) is on file with Us. We do not assume any responsibility for the validity of any assignment.
<b>Other Insurance With Us</b>	Your insurance under a like policy or policies with Us is limited to one such policy elected by You, Your beneficiary or Your estate, as the case may be, and We will return all premiums paid for all such other policies.
<b>Grace Period</b>	This Policy has a 31 day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period this Policy will stay in force.
<b>Conservation Period</b>	We offer You an additional 15 days beyond the Grace Period to pay Your premium. During this 15 day extension, this Policy is not in force unless Your premium is paid within this period. The Policy will then be renewed with no lapse in coverage.
<b>Unpaid Premium</b>	We reserve the right to deduct any premium due and unpaid from a claim payment.
<b>Reinstatement</b>	<p>If the renewal premium is not paid before the Grace Period ends or within the Conservation Period, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for Reinstatement will Reinstatement this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be Reinstated as of the approval date. Lacking such approval this Policy will be Reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.</p> <p>The Reinstated Policy will only cover losses that result from Injury or Sickness sustained after the date of Reinstatement. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any premium accepted with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.</p>
<b>Continuation of Coverage</b>	We cannot terminate Your Policy as long as You pay Your premium on time. Termination of coverage under this Policy shall be without prejudice to any continuous loss for Confinement to a Hospital or skilled nursing facility that commences while this Policy is in force and during which You are determined to be continuously totally disabled. In this Policy, "continuously totally disabled" means the complete inability of a person to engage in all the normal activities of a person of the same age and gender.
<b>Refund of Unearned Premium</b>	We will refund that part of any premium paid which covers a period beyond the end of the Policy month of Your death.
<b>Time Limit on Certain Defenses</b>	No statements, except fraudulent misstatements, made by You in the application for this Policy, shall be used to void this Policy or to deny a claim for loss incurred after 2 years from the Effective Date of this Policy. No claim for loss occurring after the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition had existed before the Effective Date of this Policy.
<b>Legal Action</b>	No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years after the time written Proof of Loss is required to be given.

**YOUR MEDICARE SUPPLEMENT POLICY**

If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.

If You have any questions about Your Policy, please write to Us and We will be happy to help You, or call Us, on Our toll free number listed above.

**Heartland National Life Insurance Company  
PO Box 2878  
Salt Lake City, Utah 84110-2878**

<p>Policy Benefits</p> <p>    Basic Benefits . . . . . Page 3</p> <p>        61st to 90th day</p> <p>        Lifetime Reserve</p> <p>        Following Lifetime Reserve</p> <p>        Part A &amp; B Blood</p> <p>        Part B Coinsurance</p> <p>    Additional Benefits (if any) . . . . . Page 3 &amp; 4</p> <p>Consideration . . . . . Page 1</p> <p>Coverage for Pre-existing Conditions . . . . . Page 1</p> <p>Definitions . . . . . Page 5</p> <p>    Benefit Period</p> <p>    Coinsurance</p> <p>    Confinement</p> <p>    Doctor</p> <p>    Hospital</p> <p>    Injury</p> <p>    Inpatient Hospital Deductible</p> <p>    Medicare</p> <p>    Medicare Part A</p> <p>    Medicare Part B</p> <p>    Medicare Eligible Expenses</p> <p>    Sickness</p> <p>Effective Date . . . . . Pages 1 &amp; 2</p>	<p>General Provisions . . . . . Pages 6 &amp; 7</p> <p>    Assignment</p> <p>    Claim Forms</p> <p>    Conformity with State Laws</p> <p>    Conservation Period</p> <p>    Continuation of Coverage</p> <p>    Electronic Claim Filing Process</p> <p>    Entire Contract; Changes</p> <p>    Grace Period</p> <p>    Legal Action</p> <p>    Misstatement of Age</p> <p>    Notice of Claim</p> <p>    Other Insurance with Us</p> <p>    Payment of Benefits</p> <p>    Proofs of Loss</p> <p>    Refund of Unearned Premium</p> <p>    Reinstatement</p> <p>    Time Limit on Certain Defenses</p> <p>    Timely Payment of Benefits</p> <p>    Unpaid Premium</p> <p>Individual Not Covered By Medicare . . . . . Page 5</p> <p>Limitations And Exclusions . . . . . Page 5</p> <p>Policy Suspension . . . . . Page 6</p> <p>Premium Changes . . . . . Page 1</p> <p>Renewal Conditions . . . . . Page 1</p> <p>Your Thirty Day Right to     Examine This Policy . . . . . Page 1</p>
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HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: Indiana

Medicare Supplement Administrative Office: PO Box 2878, Salt Lake City, UT 84110-2878

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

<p><b>Applicant Last</b>  <input type="text"/></p> <p><b>First</b> <span style="float:right"><b>MI</b></span>  <input type="text"/> <input type="text"/></p>	<p><b>Residence Address: Street:</b>  <input type="text"/></p> <p><b>City:</b>  <input type="text"/></p> <p><b>State:</b>      <b>Zip Code:</b>  <input type="text"/>      <input type="text"/>-<input type="text"/></p> <p><b>Phone:</b>                  (<input type="text"/><input type="text"/><input type="text"/>) <input type="text"/>-<input type="text"/></p>
<p><b>Check the Medicare Supplement Plan You Prefer:</b></p> <p><input type="checkbox"/> <b>Standardized Plan A</b>    <input type="checkbox"/> <b>Standardized Plan F</b></p> <p><input type="checkbox"/> <b>Standardized Plan D</b>    <input type="checkbox"/> <b>Standardized Plan G</b></p>	

Age	Date Of Birth	Gender	Height Weight	Social Security Number
<input type="text"/>	<i>Month Day Year</i> <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> <i>Male</i> <input type="checkbox"/> <i>Female</i>	<input type="text"/> <i>ft</i> <input type="text"/> <i>in</i> <input type="text"/> <i>lbs</i>	<input type="text"/> - <input type="text"/> - <input type="text"/>

MEDICARE INFORMATION

Medicare Claim Number:

Premium Payment

**Modal Premium:**                      \$ ,

**Total Submitted Premium:**      \$ ,      **Requested Effective Date:** --

or     **Draft Initial Monthly Premium**

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

Annual       Semiannual       Quarterly       Monthly Bank Draft

I authorize Bank Draft payments.      Account Type:     Checking       Savings

**Bank Routing # (9 digits):**    **Bank Account # (do not include check #):**      **Select Bank Draft Day:**  
           

Bank Name: \_\_\_\_\_

Name(s) of Depositor(s): \_\_\_\_\_

Please include a voided check.

**PART I - MEDICARE & INSURANCE INFORMATION (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. Did you turn age 65 in the last six months?  Yes  No
- 2. Did you enroll in Medicare Part B in the last six months?  Yes  No

If "Yes", what is the effective date? --

- 3. 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

- 4. 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. (If you are still covered under the other policy, leave "END" blank.)

Start -- End --

- b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?  Yes  No
- c. Was this your first time in this type of Medicare plan?  Yes  No
- d. Did you drop a Medicare Supplement plan to enroll in the Medicare plan?  Yes  No

- 5. 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

- 6. 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 and what kind of policy?

b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

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 1-8 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 benefits; or 2) is primary to Medicare and the plan terminates or the plan ceases to provide all 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 circumstance 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, 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, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then the insured person terminates coverage within 12 months or enrollment; or

- f. Upon first becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage or PACE provider and then disenrolled within 12 months
- g. Terminated coverage under a Medicare Supplement policy that covers outpatient prescription drugs and enrolled in a Medicare Part D plan during the initial enrollment period.

**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

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 premiums have 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.

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

**Fraud 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:   -   -      
(Month/Day/Year)

Applicant's Signature: \_\_\_\_\_

Writing Agent's Signature: \_\_\_\_\_

Agent Number:

Mail policy to  Agent  Applicant

**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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 #1 Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent #2 Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent #1 Name (please print) \_\_\_\_\_ Agent # \_\_\_\_\_ Split % \_\_\_\_\_  
[Grid of boxes for name, agent number, and split percentage]

Agent #2 Name (please print) \_\_\_\_\_ Agent # \_\_\_\_\_ Split % \_\_\_\_\_  
[Grid of boxes for name, agent number, and split percentage]

## HEALTH QUESTIONS

**Do not answer health questions 1-9 if you are in open enrollment or a guaranteed issued period. Please see page three for an explanation of open enrollment/guaranteed issue period information.**

**If You Answer “YES” to any part of questions 1-6 you are not eligible for coverage.**

**NOTICE TO APPLICANT: Please verify the accuracy and completeness of the medical information on this application. In complete or false information on this application could jeopardize future claims.**

- 1.) Have you been hospitalized, confined to a nursing facility or received home health care within the past 60 days or been hospitalized 3 or more times in the past 2 years?  Yes  No
- 2.) 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
- 3.) In the past two years, have you been advised by a physician or other member of the medical profession to have surgery, medical tests, or an organ transplant that has not been performed?  Yes  No
- 4.) Have you been advised by a physician or other member of the medical profession that you need to have surgery performed within the next twelve months?  Yes  No
- 5.) Do you have now, or during the past five years have you received medical treatment, or been medically advised to have treatment, surgery or taken medication for any of the following conditions:
  - a. Parkinson’s Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Alzheimer’s Disease or dementia?  Yes  No
  - b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV)?  Yes  No
  - c. Insulin Dependent Diabetes, or any Kidney Disease requiring dialysis?  Yes  No
  - d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any chronic pulmonary condition requiring the use of oxygen?  Yes  No
  - e. Internal Cancer, Leukemia, malignant melanoma, Hodgkins Disease or Lymphoma?  Yes  No
  - f. Osteoporosis with related fractures?  Yes  No
- 6.) Within the past 2 years have you had, been medically treated for, or has treatment been recommended by a physician or other member of the medical profession for:
  - a. Heart surgery, congestive heart failure, heart attack, peripheral vascular disease, arrhythmia, stroke, or transient ischemic attack (TIA)?  Yes  No
  - b. Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse or Rheumatoid Arthritis?  Yes  No
  - c. Amputation caused by disease?  Yes  No

**Additional Questions for Preferred Rating:**

If the answer to the following question is “Yes”, submit Standard premium:

- 7.) Have you used tobacco in any form in the last 2 years?  Yes  No

**Additional Health Questions:**

- 8.) Are you taking or have you taken any prescription drugs or over the counter medications within the past 12 months? If, Yes, please list the drug and the reason prescribed below.  Yes  No

Prescription Name	Reason Prescribed

**DOCTOR YOU USUALLY CONSULT - Your Primary Care Physician**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**NOTICE TO APPLICANTS REGARDING REPLACEMENT  
OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE**

HEARTLAND NATIONAL LIFE INSURANCE COMPANY  
PO BOX 2878, Salt Lake City, UT 84110-2878

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!**

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage coverage and replace it with a policy to be issued by Heartland National Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your policy or Medicare Advantage coverage only if after due consideration and acceptance by the replacing insurer, you find that purchase of this Medicare Supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

**STATEMENT TO APPLICANT BY AGENT:** I have reviewed your current medical or health insurance coverage. To the best of my knowledge this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.  Same benefits, but lower premium.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

Other (please specify).  
\_\_\_\_\_

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

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

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Producers PRINTED name and address

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

*Producer: If this replacement notice is necessary, have the insured complete and sign this form and leave it with the Applicant.*

**Heartland National Life Insurance Company**  
**Outline Of Medicare Supplement Coverage - Cover Page: 1 of 2**  
**Benefit Plans A, D, F and G**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

**Basic Benefits For Plans A-J:** Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end; Medical Expenses - Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services; Blood - First three pints of blood each year.

A	B	C	D	E	F	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance			
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible	
					Part B Excess (100%)	Part B Excess (80%)			Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
				Preventive Care NOT Covered by Medicare						Preventive Care NOT Covered by Medicare

❖ Plans currently not available for sale

\* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year \$2,000 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

**Heartland National Life Insurance Company**  
**Outline Of Medicare Supplement Coverage - Cover Page: 2 of 2**

**Basic Benefits for Plans K and L:** Similar services as plans A - J, but cost sharing for the basic benefits is at different levels.

<b>J**</b>	<b>K**</b>	<b>L**</b>
Basic Benefits	100% of Part A Hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 50% Hospice cost-sharing 50% of Medicare eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B Preventive Services	100% of Part A Hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 75% Hospice cost-sharing 75% of Medicare eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	\$[4,620] Out-of-Pocket Annual Limit***	\$[2,310] Out-of-Pocket Annual Limit***

❖ Plans currently not available for sale

\*\* Plans K and L provide for different cost-sharing for items and services than Plans A – J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges.” You will be responsible for paying excess charges.

\*\*\* The out-of-pocket annual limit will increase each year for inflation.

See the following Plan descriptions for details and exceptions.

**Preferred Premiums - Annual**  
**Zip Codes: 720-722**

	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65+	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90

*Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12*

**Preferred Premiums - Annual**  
**Zip Codes: 716-719, 723-729**

	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65+	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00

*Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12*

**Standard Premiums - Annual**

**Zip Codes: 720-722**

	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65+	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30

*Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12*

**Standard Premiums - Annual**  
**Zip Codes: 716-719, 723-729**

	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65+	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70

*Modal Factors: SA = Annual x.5, Q = Annual x.25, MBD= Annual ÷ 12*

**PREMIUM INFORMATION**

We, Heartland National Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State. Each year following the changes in Medicare's deductibles and/or benefits your rates may be adjusted at that time. Your initial premiums are guaranteed for one full year.

**DISCLOSURE PAGE**

Use this outline to compare benefits and premiums among policies.

**READ YOUR POLICY VERY CAREFULLY**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

**RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to us at: PO Box 2878, Salt Lake City, Utah 84110-2878. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued, and return all of your payments.

**POLICY REPLACEMENT**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

**NOTICE**

This policy may not fully cover all of your medical costs. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

Neither Heartland National Life nor its agents are connected with Medicare.

**COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**PLAN A**  
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day  91st day and after: -While using 60 lifetime reserve days  -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but [\$1068]  All but [\$267] a day  All but [\$534] a day  \$0  \$0	\$0  [\$267] a day  [\$534] a day  100% of Medicare eligible expenses \$0	[\$1068] (Part A deductible)  \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$133.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**Plan A (continued)**  
**MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR**

*\*\*Once you have been billed [\$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT,</b> such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$131] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$135] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next [\$131] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$135] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Part A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [\$131] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$135] (Part B Deductible) \$0
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**PLAN D  
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but [\$1068]  All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses \$0	\$0  \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

**MEDICARE (Part B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*\* Once you have been billed [\$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b> such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$135] of Medicare Approved Amounts ** Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$135] (Part B Deductible) \$0

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**Plan D (continued)**

<b>SERVICES (Medicare Part B, cont'd)</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next [\$135] of Medicare Approved Amounts**	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Part A & B**

<b>HOME HEALTH CARE</b>			
<b>MEDICARE APPROVED SERVICES</b>			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First [\$135] of Medicare Approved Amounts**	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</b>			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	\$0	Actual charges to \$40 a visit.	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved Visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	Balance
-Calendar Year Maximum	\$0	\$1600	Balance

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE,</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN F**  
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days  -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but [\$1068] All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses \$0	\$0 \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints  Additional amounts	\$0  100%	3 pints  \$0	\$0  \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**Plan F (continued)**  
**MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR**

*\*\*Once you have been billed [\$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 Generally 80%	[\$135] (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs [\$135] (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Part A & B**

<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b> -Medically necessary skilled care services and medical supplies -Durable medical equipment First [\$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 [\$135] (Part B Deductible) 20%	\$0 \$0 \$0
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**Other Benefits - Not Covered by Medicare**

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> , Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**PLAN G**  
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but [\$1068] All but [\$267] a day All but [\$534] a day  \$0 \$0	[\$1068] (Part A deductible) [\$267] a day [\$534] a day  100% of Medicare eligible expenses \$0	\$0 \$0 \$0  \$0*** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

**MEDICARE (Part B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*\* Once you have been billed [\$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b> such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$135] of Medicare Approved Amounts ** Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$135] (Part B Deductible) \$0

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**Plan G (continued)**

<b>SERVICES (Medicare Part B, cont'd)</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
Part B excess Charges (Above Medicare Approved Amounts)	\$0	80%	20%
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next [\$135] of Medicare Approved Amounts**	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Part A & B**

<b>HOME HEALTH CARE</b>			
<b>MEDICARE APPROVED SERVICES</b>			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First [\$135] of Medicare Approved Amounts**	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</b>			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	\$0	Actual charges to \$40 a visit.	Balance
-Number of visits covered (must be received with- in 8 weeks of last Medicare Approved Visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	Balance
-Calendar Year Maximum	\$0	\$1,600	Balance

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> , Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum



**IMPORTANT NOTICE**

Please read the copy of the Application attached to this Policy. Carefully check the Application and write to Heartland National Life Insurance Company at P.O. Box 2878, Salt Lake City, Utah 84110-2878, within 1- days if any information shown on it is not correct and complete, or if any past medical history has been left out of the Application. This Application is part of the Policy and the Policy was issued on the basis that the answers to all questions and the information shown on the Application are correct and complete.

If you have any questions please contact the Policyowner Service Department at {1 (800) 352-5170}.

Policyowner Service Department  
{P.O. Box 2878  
Salt Lake City, Utah 84110  
1-(800)-916-7971}

Agent:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
(800) 852-5494 (501) 371-2640

HPF-AR

*You have selected Plan F, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

- 61st to 90th Day Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.
- Lifetime Reserve Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.
- Following the Lifetime Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

- Part A & B Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

- Part B Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

## **ADDITIONAL BENEFITS**

- Medicare Part A Deductible** When You are confined as an inpatient to a Hospital, We will pay You the Medicare Part A Inpatient Hospital Deductible in any Medicare Benefit Period.
- Skilled Nursing Facility Benefit** We will pay You the actual billed charges up to the daily coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital skilled nursing facility care eligible under Medicare, Part A.
- Medicare Part B Deductible** We will pay You for all Eligible Expenses used to satisfy Your Medicare Part B deductible amount per calendar year regardless of Hospital Confinement.
- 100% of the Medicare Part B Excess Charges** We will pay You 100% of the difference between the actual Medicare Part B billed charge, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.
- Medically Necessary Emergency Care in a Foreign Country** When You are traveling outside the United States and require Emergency Care, we will pay You 80% of the billed charges after a calendar year deductible of \$250. Emergency Care shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset beginning during the first 60 consecutive days of each trip outside the United States. Medical services must be of the type that Medicare would have covered if the care had been received in the United States. This benefit is subject to a lifetime maximum of \$50,000 dollars.

## ENDORSEMENT

This Endorsement modifies, and is made a part of, Your Policy. Please attach this Endorsement to Your Policy.

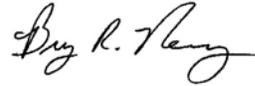
The following benefit is added to your policy under the "Additional Benefits" section on page 3:

**Skilled  
Nursing  
Facility  
Benefit** We will pay You the actual billed charges up to the daily Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital skilled nursing facility care eligible under Medicare Part A.

This Endorsement has no effect on and in no way modifies any other benefits in your Policy.



President



Secretary



SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

## Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved	Actuarial Memorandum	90020-A AR, 90020-D AR, 90020-F AR, 90020-G AR	New		Medicare Supplement Actuarial Memorandum_AR.pdf
Approved	Rate Schedule	90020-A AR, 90020-D AR, 90020-F AR, 90020-G AR	New		AR 90000 rates.pdf

# HEARTLAND NATIONAL LIFE INSURANCE COMPANY ACTUARIAL MEMORANDUM

## Medicare Supplement Policy Forms 90000-A, 90000-D, 90000-F, and 90000-G Arkansas

### Scope and Purpose

The purpose of this filing is to demonstrate that the anticipated loss ratio of these forms meet the minimum requirements of your state. This Actuarial Memorandum is not intended to be used for any purpose other than described above.

### Description of Benefits

These policy forms are individual guaranteed renewable Medicare Supplement policy forms that meet the benefit requirements for these plans as defined by the NAIC Model regulation. A summary of the benefits follows:

<u>Policy Form</u>	<u>Plan</u>	<u>Benefit Description</u>
90000-A	A	Core Benefits*
90000-D	D	Core Benefits*, skilled nursing coinsurance, Part A deductible, foreign travel, at-home recovery
90000-F	F	Core Benefits*, skilled nursing coinsurance, Part A & Part B deductible, Part B Excess, foreign travel
90000-G	G	Core Benefits*, skilled nursing coinsurance, Part A deductible, Part B Excess (80%), foreign travel, at-home recovery

\*Core Benefits: Part A coinsurance plus 365 additional days after Medicare benefits end, Part B coinsurance, and the first 3 pints of blood each year.

### Morbidity

Claim costs are based on statistics provided from the following sources:

- 1.) American Academy of Actuaries Medicare Supplement Experience Report, June 2000
- 2.) Proprietary Medicare Supplement insurance client data and input from the Company's reinsurer

Selection Factors:

<u>Year</u>	<u>Factor</u>
1	0.930
2	1.015
3+	1.015

**Medical Trend**

Claim costs and premiums have been calculated at 2009 levels and the assumed future medical trend is 8.0% to account for medical provider reimbursements rate increases, utilization changes, medical cost shifting, and new medical procedures and technology.

**Mortality & Lapses Rates**

Mortality is calculated using the 2000 US Life Mortality Table

Voluntary lapses are based on the following table:

<u>Year</u>	<u>Issue Ages 65-72</u>	<u>Issue Ages 73+</u>
1	16.0%	14.0%
2	14.0%	12.0%
3	12.0%	10.0%

**Expenses Allowances**

Expenses:

Issue:	\$69.00 per policy issued 3.00% of 1 <sup>st</sup> year premium
Maintenance:	\$48.40 per policy in force
Overhead:	2.00% of premium
Premium Tax:	2.00% of premium

**Marketing Method**

This product will be marketed through agents and brokers on an individual basis.

**Gross Premium Structure**

Premium rates are based upon a zip code and preferred/standard rate structure. Gross annual premiums are shown in Exhibit 2. There are no modal loadings.

**Issue Age Range**

These policy forms will be issued to all individuals age 65+ who are eligible for Medicare. They will also be issued to disabled individuals eligible for Medicare in those states where mandated by law.

**Underwriting**

The policy will be issued to persons eligible for Medicare based on limited underwriting with yes/no questions. Persons applying for coverage during the open enrollment period will not be underwritten and will be offered preferred rates.

**Distribution of Business**

<b>Issue Age</b>	<b>Distribution</b>	<b>Plan</b>	<b>Distribution</b>
65	20.0%	A	5%
66-67	20.0%	D	10%
68-70	20.0%	F	75%
71-75	17.5%	G	10%
76-80	15.0%		
81-85	5.0%		
86+	2.5%		

<b>Gender</b>	<b>Distribution</b>
Male	40%
Female	60%
<b>UW Class</b>	<b>Distribution</b>
Preferred	85%
Standard	15%

**Claim Liability and Reserves**

The claim reserves will be calculated based on a completion factor approach.

**Anticipated Lifetime Loss Ratio**

The lifetime loss ratio is calculated as the present value of incurred claims divided by the present value of earned premiums. An interest rate of 4.00% is used in the present value calculations. The anticipated loss ratio for these forms meets or exceeds 65%. Durational loss ratios are shown in Exhibit 1. The overall anticipated lifetime loss ratio for this form and its riders exceeds the minimum standard set forth by the regulations of this state, as they apply to guaranteed renewable policy forms providing these types of benefits.

**Actuarial Certification**

I certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws of this State;
2. This rate filing complies with all appropriate Actuarial Standards of Practice, including Actuarial Standard of Practice #8, "Regulatory Filings for Rates and Financial Projections for Health Plans";
3. The premiums are reasonable in relation to the benefits provided; and the premium schedule is not excessive, inadequate, nor unfairly discriminatory.



Bryan R. Neary FSA, MAAA  
CSG Actuarial, LLC  
February 12, 2009



Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12

Heartland - Form 90000 Attained Age Rates								
State: AR Zip Codes: 716-719, 723-729 Preferred								
Age	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
66	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
67	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
68	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
69	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
70	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
71	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
72	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
73	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
74	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
75	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
76	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
77	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
78	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
79	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
80	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
81	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
82	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
83	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
84	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
85	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
86	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
87	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
88	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
89	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
90	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
91	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
92	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
93	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
94	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
95	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
96	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
97	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00

<b>98</b>	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
<b>99</b>	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00

Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12



Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12

Heartland - Form 90000 Attained Age Rates								
State: AR Zip Codes: 716-719, 723-729 Standard								
Age	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
66	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
67	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
68	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
69	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
70	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
71	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
72	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
73	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
74	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
75	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
76	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
77	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
78	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
79	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
80	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
81	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
82	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
83	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
84	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
85	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
86	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
87	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
88	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
89	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
90	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
91	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
92	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
93	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
94	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
95	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
96	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
97	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70

<b>98</b>	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
<b>99</b>	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70

Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
Company Tracking Number: 90000 AR  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement  
Project Name/Number: 90000/90000

## Supporting Document Schedules

<b>Satisfied -Name:</b> Flesch Certification	<b>Review Status:</b> Accepted for Informational Purposes	02/13/2009
<b>Comments:</b>		
<b>Attachments:</b>		
AR A Flesch Certification.pdf		
AR D Flesch Certification.pdf		
AR F Flesch Certification.pdf		
AR G Flesch Certification.pdf		
<b>Satisfied -Name:</b> Application	<b>Review Status:</b> Approved	02/13/2009
<b>Comments:</b>		
See Form Schedule		
<b>Satisfied -Name:</b> Health - Actuarial Justification	<b>Review Status:</b> Approved	02/13/2009
<b>Comments:</b>		
See Rate/Rule Schedule		
<b>Satisfied -Name:</b> Outline of Coverage	<b>Review Status:</b> Approved	02/13/2009
<b>Comments:</b>		
See Form Schedule		
<b>Satisfied -Name:</b> Form and Rate Certification	<b>Review Status:</b> Accepted for Informational Purposes	02/13/2009
<b>Comments:</b>		
<b>Attachment:</b>		
Form and Rate Certification AR.pdf		

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
Company Tracking Number: 90000 AR  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement  
Project Name/Number: 90000/90000

**Satisfied -Name:** Third Party Authorization **Review Status:** Accepted for Informational Purposes 02/13/2009

**Comments:**

**Attachment:**

Third Party Authorization 11-08.pdf

**Satisfied -Name:** Redlined Copies **Review Status:** Accepted for Informational Purposes 02/13/2009

**Comments:**

**Attachments:**

90000-a\_ar redlined.pdf  
90000-d\_ar redlined.pdf  
90000-f\_ar redlined.pdf  
90000-g\_ar redlined.pdf  
A-HNL 08 AR redlined.pdf  
Olc90000-2009\_ar redlined.pdf

**Satisfied -Name:** 6-23-09 Redlined Application **Review Status:** Accepted for Informational Purposes 07/01/2009

**Comments:**

**Attachment:**

A-HNL-09\_ar app redlined.pdf

**Satisfied -Name:** Redlined Plan F Page 3 **Review Status:** Approved 07/10/2009

**Comments:**

**Attachment:**

f\_ar page 3 redlined.pdf

## CERTIFICATION

RE: 90020-A AR

This is to certify that the attached Medicare Supplement Policy, 90020-A AR has achieved a Flesch Reading Ease Score of 45.5 and complies with the requirements of Arkansas Stat. Ann. 66-3251 through 6-3258 cited as the Life and Disability Insurance Policy Language Simplification Act.

Dated this January 19, 2009

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Christopher M. McDaniel". The signature is fluid and cursive, with a large initial "C" and "M".

By  
Christopher M. McDaniel  
President and CEO

## CERTIFICATION

RE: 90020-D AR

This is to certify that the attached Medicare Supplement Policy, 90020-A AR has achieved a Flesch Reading Ease Score of 44.9 and complies with the requirements of Arkansas Stat. Ann. 66-3251 through 6-3258 cited as the Life and Disability Insurance Policy Language Simplification Act.

Dated this January 19, 2009

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Christopher M. McDaniel". The signature is fluid and cursive, with a large initial "C" and "M".

By  
Christopher M. McDaniel  
President and CEO

## CERTIFICATION

RE: 90020-F AR

This is to certify that the attached Medicare Supplement Policy, 90020-A AR has achieved a Flesch Reading Ease Score of 44.9 and complies with the requirements of Arkansas Stat. Ann. 66-3251 through 6-3258 cited as the Life and Disability Insurance Policy Language Simplification Act.

Dated this January 19, 2009

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Christopher M. McDaniel". The signature is fluid and cursive, with a large initial "C" and "M".

By  
Christopher M. McDaniel  
President and CEO

## CERTIFICATION

RE: 90020-G AR

This is to certify that the attached Medicare Supplement Policy, 90020-A AR has achieved a Flesch Reading Ease Score of 45.1 and complies with the requirements of Arkansas Stat. Ann. 66-3251 through 6-3258 cited as the Life and Disability Insurance Policy Language Simplification Act.

Dated this January 19, 2009

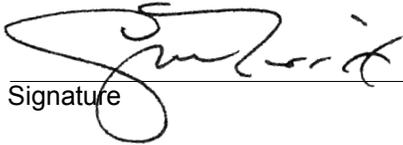
HEARTLAND NATIONAL LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Christopher M. McDaniel". The signature is fluid and cursive, with a large initial "C" and "M".

By  
Christopher M. McDaniel  
President and CEO

**State of Arkansas  
Form and Rate Use Certification**

I, Christopher M. McDaniel, hereby certify that the forms and rates contained in this filing, when approved, will not be used in the State of Arkansas until such time that the Corporate Amendments Application for Heartland National Life Insurance Company has been approved by the Arkansas Insurance Department.



\_\_\_\_\_  
Signature

Christopher M. McDaniel  
\_\_\_\_\_  
Printed Name

President, Chief Executive Officer & Chairman of the Board  
\_\_\_\_\_  
Title

January 16, 2009  
\_\_\_\_\_  
Date



November 19, 2008

RE: Form Filing Authorization

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

This authorization shall be valid until revoked by Heartland.

Sincerely,

A handwritten signature in black ink, appearing to read "McDaniel", is written over a large, stylized loop.

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

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

***YOU HAVE SELECTED PLAN A. THIS POLICY PROVIDES BENEFITS WHICH SUPPLEMENT MEDICARE. IT IS GUARANTEED RENEWABLE FOR YOUR LIFETIME. WE HAVE THE RIGHT TO CHANGE PREMIUMS ONLY ON A CLASS BASIS BY STATE.***

**Medicare Supplement Policy** We Insure You, named as the Insured on the Policy Schedule. We promise to pay the benefits provided in this Policy for covered losses that are incurred while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached. **Notice to Buyer: This Policy may not cover all of Your medical expenses.**

**Your Thirty Day Right to Examine This Policy** If for any reason You are not satisfied with this Policy, You may return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all premiums You paid to Us and then You and We will be in the same position as if a Policy had never been issued.

**Coverage for Pre-existing Conditions** Benefits will be paid for all covered losses under this Policy, even those caused by a Sickness, Injury or physical condition that existed before the Effective Date of the Policy. Loss occurring during a Confinement is considered to commence with the first day of such Confinement.

**Renewal Conditions** You may renew this Policy as long as You live. To renew, just pay a renewal premium. It must be paid on or before the end of the premium period, within the Grace Period, or during the Conservation Period. After this Policy is in force We cannot refuse to renew it or place any restrictions on it if the premium is paid on time.

**Premium Changes** We will not change the premiums for this Policy during Your first year of coverage within the 90000 Series. Thereafter, we can change them, but only if We change them for all policies like Yours in Your state on a class basis. A class is determined by benefits selected and year of issue. No rate adjustment may be made on an individual basis. Notice will be given to You at least 31 days before any premium change.

Your Policy benefits automatically change in accordance with Policy provisions whenever Medicare benefits change. After Your first year of coverage, the renewal premium for this Policy may change on a renewal date following the Effective Date of any change in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. Any such premium change will be based on the actuarial computations that We then use to determine the renewal premium.

**Consideration & Effective Date** This Policy is issued in consideration of the statements in Your application for insurance that is attached to and is made a part of this Policy, and the payment of the initial premium. This payment will keep the Policy in force until the first renewal date. The initial premium and the first renewal date are shown on Page 2. Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown on Page 2. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.

  
 Secretary

  
 President

**POLICY SCHEDULE**

Plan:

Policy Number:

Insured:

Effective Date:

First Renewal Date:

Initial Premium:

Endorsements:

**Renewal Premiums**

Annual

Semi-Annual

Quarterly

Monthly Bank Draft

*You have selected Plan A, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

**61st to 90th Day  
Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.

**Lifetime  
Reserve  
Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.

**Following the  
Lifetime  
Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

**Part A & B  
Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

**Part B  
Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

*(This Page has been left blank intentionally.)*

## DEFINITIONS

*The person named as the "Insured" on Page 2 of this Policy is referred to in this Policy as You, Your, Yours, or Insured and Heartland National Life Insurance Company as We, Our or Us.*

<b>Benefit Period</b>	Means a period that begins, after the Effective Date of this Policy, with the first day of Hospital Confinement and ends at the close of 60 consecutive days during which You were not confined to a Hospital or skilled nursing facility.
<b>Coinsurance</b>	Means the difference between the Medicare approved amount and the Medicare payment after You have satisfied the applicable Medicare deductibles.
<b>Confinement</b>	Means medically required stay as a resident inpatient in a Hospital or skilled nursing facility. It must be on the specific recommendation and under the general supervision of a Doctor.
<b>Doctor</b>	Means a duly licensed person practicing in the healing arts and acting within the scope of that license in treating a Sickness or Injury. A Doctor must be other than an immediate member of Your family.
<b>Hospital</b>	Means a place that is licensed as a Hospital pursuant to law and is legally operated for the care and treatment of sick or injured persons at their expense. A Hospital does not include the following kinds of facilities (including units in a Hospital used for such care); (a) convalescent, nursing home, rest home, or nursing care facilities; (b) places that primarily treat the aged, drug addicts or alcoholics; and (c) facilities that primarily provide custodial or educational care.
<b>Injury</b>	Means bodily harm sustained by You which: (a) is the direct result of an accident or trauma that occurs while Your Policy is in force; and (b) is not related to Sickness, bodily infirmity or any other cause.
<b>Inpatient Hospital Deductible</b>	Means the initial Hospital expense incurred during a Benefit Period for which You are responsible under Medicare.
<b>Medicare</b>	Means Title XVIII of the United States Social Security Act of 1965, as then constituted or later amended.
<b>Medicare Part A</b>	Means the program under Medicare officially called "Hospital Insurance Benefit for the Aged and Disabled".
<b>Medicare Part B</b>	Means the program under Medicare officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled".
<b>Medicare Eligible Expenses</b>	Means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
<b>Sickness</b>	Means illness or disease of an insured person.

## LIMITATIONS & EXCLUSIONS

<b>Limitations &amp; Exclusions</b>	We will not pay benefits under this Policy for: <ul style="list-style-type: none"><li>a) Any expense which is not eligible for payment under Medicare, unless otherwise covered in Your Policy or by optional endorsement; or</li><li>b) Any expense which You are not legally obligated to pay.</li></ul>
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## ELIGIBILITY FOR COVERAGE

<b>Individual Not Covered by Medicare</b>	If You have not established entitlement to benefits under Medicare, We will provide benefits under this Policy as though You had established entitlement.
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## POLICY SUSPENSION

<b>Medicaid Entitlement</b>	<p>If You apply for and become entitled to medical assistance under Medicaid, the benefits and premiums under Your Policy will be suspended, if requested, for up to 24 months during Your Medicaid Entitlement. You must request this suspension within 90 days of becoming entitled to Medicaid.</p> <p>If You lose Your entitlement to Medicaid while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Medicaid Entitlement and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Medicaid Entitlement is terminated.</p>
<b>Group Health Plan Coverage</b>	<p>If You were eligible for, and purchased this Policy by reason of disability and You become covered under an employer or union based group health plan, Your benefits and premiums under this Policy will be suspended, if requested, while You are covered under the group health plan.</p> <p>If You lose coverage under Your group health plan while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Group Health Plan Coverage and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Group Health Plan Coverage is terminated.</p>
<b>Reinstitution</b>	<p>Your reinstated Policy will provide the same or substantially equivalent coverage that was in effect when your Policy was suspended. The premium for Your reinstated Policy will be on the same terms that would have applied had Your Policy not been suspended.</p>

## GENERAL PROVISIONS

<b>Entire Contract; Changes</b>	<p>This Policy with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.</p>
<b><u>Conformity with State Laws</u></b>	<p><u>Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that Effective Date is amended to conform to the minimum requirements of such laws.</u></p>
<b><u>Notice of Claim</u></b>	<p><u>Written Notice of Claim must be given within 6 months after a covered loss begins or as soon as possible. The notice can be given to Us at the address shown on Page 8, or to any one of Our agents. The notice should include Your name and Policy number.</u></p>
<b>Claim Forms</b>	<p>When We receive Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not sent to You within 15 days after giving such notice, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.</p>
<b>Electronic Claim Filing Process</b>	<p>Your health care providers will usually submit electronically to Medicare the billed charges for any medical or Hospital expenses You incur. Medicare then processes the benefits for expenses eligible under Part A and/or B, and then passes Your claim electronically to Us for consideration of benefits under Your Policy. We will accept Medicare's electronic submission of Your claim to Us as Your Notice of Claim and Your Claim Form. For consideration of expenses that are not submitted electronically to Us, a paper copy of Your Medicare Summary Notice can serve as Your Notice of Claim and Claim Form. The Medicare Summary Notice shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare Summary Notice to Us or Your health care provider may submit it to Us on Your behalf.</p>
<b>Proofs of Loss</b>	<p>Written Proof of Loss must be given to Us within 90 days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.</p>

<b>Payment of Benefits</b>	All benefits will be paid to You, or Your assignee. Benefits unpaid at Your death may be paid to Your estate or We may pay up to \$1,000 to any relative of Yours who is entitled to them. Any payment made in good faith will fully release Us to the extent of that payment.
<b>Timely Payment of Benefits</b>	Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.
<b>Assignment</b>	No assignment of benefits under this Policy shall be binding upon Us unless the original (or copy of it) is on file with Us. We do not assume any responsibility for the validity of any assignment.
<b>Other Insurance With Us</b>	Your insurance under a like policy or policies with Us is limited to one such policy elected by You, Your beneficiary or Your estate, as the case may be, and We will return all premiums paid for all such other policies.
<b>Grace Period</b>	This Policy has a 31 day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period this Policy will stay in force.
<b>Conservation Period</b>	We offer You an additional 15 days beyond the Grace Period to pay Your premium. During this 15 day extension, this Policy is not in force unless Your premium is paid within this period. The Policy will then be renewed with no lapse in coverage.
<b>Unpaid Premium</b>	We reserve the right to deduct any premium due and unpaid from a claim payment.
<b>Reinstatement</b>	<p>If the renewal premium is not paid before the Grace Period ends or within the Conservation Period, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for Reinstatement will Reinstatement this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be Reinstated as of the approval date. Lacking such approval this Policy will be Reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.</p> <p>The Reinstated Policy will only cover losses that result from Injury or Sickness sustained after the date of Reinstatement. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any premium accepted with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.</p>
<b>Continuation of Coverage</b>	We cannot terminate Your Policy as long as You pay Your premium on time. Termination of coverage under this Policy shall be without prejudice to any continuous loss for Confinement to a Hospital or skilled nursing facility that commences while this Policy is in force and during which You are determined to be continuously totally disabled. In this Policy, "continuously totally disabled" means the complete inability of a person to engage in all the normal activities of a person of the same age and gender.
<b>Refund of Unearned Premium</b>	We will refund that part of any premium paid which covers a period beyond the end of the Policy month of Your death.
<b>Time Limit on Certain Defenses</b>	No statements, except fraudulent misstatements, made by You in the application for this Policy, shall be used to void this Policy or to deny a claim for loss incurred after 2 years from the Effective Date of this Policy. No claim for loss occurring after the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition had existed before the Effective Date of this Policy.
<b>Legal Action</b>	No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years after the time written Proof of Loss is required to be given.

**YOUR MEDICARE SUPPLEMENT POLICY**

If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.

If You have any questions about Your Policy, please write to Us and We will be happy to help You, or call Us, on Our toll free number listed above.

**Heartland National Life Insurance Company**  
**PO Box 2878**  
**Salt Lake City, Utah 84110-2878**

<p>Policy Benefits</p> <p>  Basic Benefits ..... Page 3</p> <p>    61st to 90th day</p> <p>    Lifetime Reserve</p> <p>    Following Lifetime Reserve</p> <p>    Part A &amp; B Blood</p> <p>    Part B Coinsurance</p> <p>  Additional Benefits (if any) ..... Page 3 &amp; 4</p> <p>Consideration ..... Page 1</p> <p>Coverage for Pre-existing Conditions ..... Page 1</p> <p>Definitions ..... Page 5</p> <p>  Benefit Period</p> <p>  Coinsurance</p> <p>  Confinement</p> <p>  Doctor</p> <p>  Hospital</p> <p>  Injury</p> <p>  Inpatient Hospital Deductible</p> <p>  Medicare</p> <p>  Medicare Part A</p> <p>  Medicare Part B</p> <p>  Medicare Eligible Expenses</p> <p>  Sickness</p> <p>Effective Date ..... Pages 1 &amp; 2</p>	<p>General Provisions ..... Pages 6 &amp; 7</p> <p>  Assignment</p> <p>  Claim Forms</p> <p>  Conformity with State Laws</p> <p>  Conservation Period</p> <p>  Continuation of Coverage</p> <p>  Electronic Claim Filing Process</p> <p>  Entire Contract; Changes</p> <p>  Grace Period</p> <p>  Legal Action</p> <p>  Misstatement of Age</p> <p>  Notice of Claim</p> <p>  Other Insurance with Us</p> <p>  Payment of Benefits</p> <p>  Proofs of Loss</p> <p>  Refund of Unearned Premium</p> <p>  Reinstatement</p> <p>  Time Limit on Certain Defenses</p> <p>  Timely Payment of Benefits</p> <p>  Unpaid Premium</p> <p>Individual Not Covered By Medicare ..... Page 5</p> <p>Limitations And Exclusions ..... Page 5</p> <p>Policy Suspension ..... Page 6</p> <p>Premium Changes ..... Page 1</p> <p>Renewal Conditions ..... Page 1</p> <p>Your Thirty Day Right to   Examine This Policy ..... Page 1</p>
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**YOU HAVE SELECTED PLAN D. THIS POLICY PROVIDES BENEFITS WHICH SUPPLEMENT MEDICARE. IT IS GUARANTEED RENEWABLE FOR YOUR LIFETIME. WE HAVE THE RIGHT TO CHANGE PREMIUMS ONLY ON A CLASS BASIS BY STATE.**

**Medicare Supplement Policy** We Insure You, named as the Insured on the Policy Schedule. We promise to pay the benefits provided in this Policy for covered losses that are incurred while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached. **Notice to Buyer: This Policy may not cover all of Your medical expenses.**

**Your Thirty Day Right to Examine This Policy** If for any reason You are not satisfied with this Policy, You may return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all premiums You paid to Us and then You and We will be in the same position as if a Policy had never been issued.

**Coverage for Pre-existing Conditions** Benefits will be paid for all covered losses under this Policy, even those caused by a Sickness, Injury or physical condition that existed before the Effective Date of the Policy. Loss occurring during a Confinement is considered to commence with the first day of such Confinement.

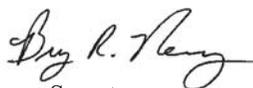
**Renewal Conditions** You may renew this Policy as long as You live. To renew, just pay a renewal premium. It must be paid on or before the end of the premium period, within the Grace Period, or during the Conservation Period. After this Policy is in force We cannot refuse to renew it or place any restrictions on it if the premium is paid on time.

**Premium Changes** We will not change the premiums for this Policy during Your first year of coverage within the 90000 Series. Thereafter, we can change them, but only if We change them for all policies like Yours in Your state on a class basis. A class is determined by benefits selected and year of issue. No rate adjustment may be made on an individual basis. Notice will be given to You at least 31 days before any premium change.

Your Policy benefits automatically change in accordance with Policy provisions whenever Medicare benefits change. After Your first year of coverage, the renewal premium for this Policy may change on a renewal date following the Effective Date of any change in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. Any such premium change will be based on the actuarial computations that We then use to determine the renewal premium.

**Consideration & Effective Date** This Policy is issued in consideration of the statements in Your application for insurance that is attached to and is made a part of this Policy, and the payment of the initial premium. This payment will keep the Policy in force until the first renewal date. The initial premium and the first renewal date are shown on Page 2. Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown on Page 2. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.

  
Secretary

  
President

**POLICY SCHEDULE**

Plan:

Policy Number:

Insured:

Effective Date:

First Renewal Date:

Initial Premium:

Endorsements:

**Renewal Premiums**

Annual

Semi-Annual

Quarterly

Monthly Bank Draft

*You have selected Plan D, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

- 61st to 90th Day Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.
- Lifetime Reserve Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.
- Following the Lifetime Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

- Part A & B Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

- Part B Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

## **ADDITIONAL BENEFITS**

- Medicare Part A Deductible** When You are confined as an inpatient to a Hospital, We will pay You the Medicare Part A Inpatient Hospital Deductible in any Medicare Benefit Period.
- Skilled Nursing Facility Benefit** We will pay You the actual billed charges up to the daily Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital skilled nursing facility care eligible under Medicare Part A.
- Medically Necessary Emergency Care in a Foreign Country** When You are traveling outside the United States and require Emergency Care, We will pay You 80% of the billed charges after a calendar year deductible of \$250. Emergency Care shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset beginning during the first 60 consecutive days of each trip outside the United States. Medical services must be of the type that Medicare would have covered if the care had been received in the United States. This benefit is subject to a lifetime maximum of \$50,000 dollars.

### ADDITIONAL BENEFITS (continued)

#### **At-Home Recovery Benefit**

We will pay You the actual charge, up to \$40 dollars per visit, for short term assistance with Activities of Daily Living furnished in Your Home by a Care Provider when you are recovering from a Sickness, Injury or surgery. You may receive up to 7 visits per week, with a calendar year maximum of 40 visits or \$1,600 dollars.

To receive benefits, Your Doctor must certify that the type and frequency of At-Home Recovery Visits are necessary because of a condition for which Your home care plan of treatment was approved by Medicare. All visits must be received during the period in which You are receiving Medicare approved home health care services, or within 8 weeks of the last date of service of a Medicare approved home health visit. In no event shall the total number of At-Home Recovery Visits exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

For purposes of this benefit, the following definitions shall apply:

(i) "Activities of Daily Living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings. (ii) "Care Provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry. (iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A Hospital or skilled nursing facility shall not be considered the insured's place of residence. (iv) "At-Home Recovery Visit" means the period of a visit required to provide At-Home Recovery Care, without limit on the duration of the visit, except each consecutive 4 hours in a 24 hour period of services provided by a Care Provider is one visit.

Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government program; and (ii) care provided by family members, unpaid volunteers or providers who are not Care Providers.

## DEFINITIONS

*The person named as the "Insured" on Page 2 of this Policy is referred to in this Policy as You, Your, Yours, or Insured and Heartland National Life Insurance Company as We, Our or Us.*

<b>Benefit Period</b>	Means a period that begins, after the Effective Date of this Policy, with the first day of Hospital Confinement and ends at the close of 60 consecutive days during which You were not confined to a Hospital or skilled nursing facility.
<b>Coinsurance</b>	Means the difference between the Medicare approved amount and the Medicare payment after You have satisfied the applicable Medicare deductibles.
<b>Confinement</b>	Means medically required stay as a resident inpatient in a Hospital or skilled nursing facility. It must be on the specific recommendation and under the general supervision of a Doctor.
<b>Doctor</b>	Means a duly licensed person practicing in the healing arts and acting within the scope of that license in treating a Sickness or Injury. A Doctor must be other than an immediate member of Your family.
<b>Hospital</b>	Means a place that is licensed as a Hospital pursuant to law and is legally operated for the care and treatment of sick or injured persons at their expense. A Hospital does not include the following kinds of facilities (including units in a Hospital used for such care); (a) convalescent, nursing home, rest home, or nursing care facilities; (b) places that primarily treat the aged, drug addicts or alcoholics; and (c) facilities that primarily provide custodial or educational care.
<b>Injury</b>	Means bodily harm sustained by You which: (a) is the direct result of an accident or trauma that occurs while Your Policy is in force; and (b) is not related to Sickness, bodily infirmity or any other cause.
<b>Inpatient Hospital Deductible</b>	Means the initial Hospital expense incurred during a Benefit Period for which You are responsible under Medicare.
<b>Medicare</b>	Means Title XVIII of the United States Social Security Act of 1965, as then constituted or later amended.
<b>Medicare Part A</b>	Means the program under Medicare officially called "Hospital Insurance Benefit for the Aged and Disabled".
<b>Medicare Part B</b>	Means the program under Medicare officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled".
<b>Medicare Eligible Expenses</b>	Means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
<b>Sickness</b>	Means illness or disease of an insured person.

## LIMITATIONS & EXCLUSIONS

<b>Limitations &amp; Exclusions</b>	We will not pay benefits under this Policy for: <ul style="list-style-type: none"><li>a) Any expense which is not eligible for payment under Medicare, unless otherwise covered in Your Policy or by optional endorsement; or</li><li>b) Any expense which You are not legally obligated to pay.</li></ul>
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## ELIGIBILITY FOR COVERAGE

<b>Individual Not Covered by Medicare</b>	If You have not established entitlement to benefits under Medicare, We will provide benefits under this Policy as though You had established entitlement.
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## POLICY SUSPENSION

<b>Medicaid Entitlement</b>	<p>If You apply for and become entitled to medical assistance under Medicaid, the benefits and premiums under Your Policy will be suspended, if requested, for up to 24 months during Your Medicaid Entitlement. You must request this suspension within 90 days of becoming entitled to Medicaid.</p> <p>If You lose Your entitlement to Medicaid while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Medicaid Entitlement and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Medicaid Entitlement is terminated.</p>
<b>Group Health Plan Coverage</b>	<p>If You were eligible for, and purchased this Policy by reason of disability and You become covered under an employer or union based group health plan, Your benefits and premiums under this Policy will be suspended, if requested, while You are covered under the group health plan.</p> <p>If You lose coverage under Your group health plan while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Group Health Plan Coverage and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Group Health Plan Coverage is terminated.</p>
<b>Reinstitution</b>	<p>Your reinstated Policy will provide the same or substantially equivalent coverage that was in effect when your Policy was suspended. The premium for Your reinstated Policy will be on the same terms that would have applied had Your Policy not been suspended.</p>

## GENERAL PROVISIONS

<b>Entire Contract; Changes</b>	<p>This Policy with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.</p>
<b><u>Conformity with State Laws</u></b>	<p><u>Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that Effective Date is amended to conform to the minimum requirements of such laws.</u></p>
<b><u>Notice of Claim</u></b>	<p><u>Written Notice of Claim must be given within 6 months after a covered loss begins or as soon as possible. The notice can be given to Us at the address shown on Page 8, or to any one of Our agents. The notice should include Your name and Policy number.</u></p>
<b>Claim Forms</b>	<p>When We receive Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not sent to You within 15 days after giving such notice, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.</p>
<b>Electronic Claim Filing Process</b>	<p>Your health care providers will usually submit electronically to Medicare the billed charges for any medical or Hospital expenses You incur. Medicare then processes the benefits for expenses eligible under Part A and/or B, and then passes Your claim electronically to Us for consideration of benefits under Your Policy. We will accept Medicare's electronic submission of Your claim to Us as Your Notice of Claim and Your Claim Form. For consideration of expenses that are not submitted electronically to Us, a paper copy of Your Medicare Summary Notice can serve as Your Notice of Claim and Claim Form. The Medicare Summary Notice shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare Summary Notice to Us or Your health care provider may submit it to Us on Your behalf.</p>
<b>Proofs of Loss</b>	<p>Written Proof of Loss must be given to Us within 90 days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.</p>

<b>Payment of Benefits</b>	All benefits will be paid to You, or Your assignee. Benefits unpaid at Your death may be paid to Your estate or We may pay up to \$1,000 to any relative of Yours who is entitled to them. Any payment made in good faith will fully release Us to the extent of that payment.
<b>Timely Payment of Benefits</b>	Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.
<b>Assignment</b>	No assignment of benefits under this Policy shall be binding upon Us unless the original (or copy of it) is on file with Us. We do not assume any responsibility for the validity of any assignment.
<b>Other Insurance With Us</b>	Your insurance under a like policy or policies with Us is limited to one such policy elected by You, Your beneficiary or Your estate, as the case may be, and We will return all premiums paid for all such other policies.
<b>Grace Period</b>	This Policy has a 31 day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period this Policy will stay in force.
<b>Conservation Period</b>	We offer You an additional 15 days beyond the Grace Period to pay Your premium. During this 15 day extension, this Policy is not in force unless Your premium is paid within this period. The Policy will then be renewed with no lapse in coverage.
<b>Unpaid Premium</b>	We reserve the right to deduct any premium due and unpaid from a claim payment.
<b>Reinstatement</b>	<p>If the renewal premium is not paid before the Grace Period ends or within the Conservation Period, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for Reinstatement will Reinstatement this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be Reinstated as of the approval date. Lacking such approval this Policy will be Reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.</p> <p>The Reinstated Policy will only cover losses that result from Injury or Sickness sustained after the date of Reinstatement. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any premium accepted with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.</p>
<b>Continuation of Coverage</b>	We cannot terminate Your Policy as long as You pay Your premium on time. Termination of coverage under this Policy shall be without prejudice to any continuous loss for Confinement to a Hospital or skilled nursing facility that commences while this Policy is in force and during which You are determined to be continuously totally disabled. In this Policy, "continuously totally disabled" means the complete inability of a person to engage in all the normal activities of a person of the same age and gender.
<b>Refund of Unearned Premium</b>	We will refund that part of any premium paid which covers a period beyond the end of the Policy month of Your death.
<b>Time Limit on Certain Defenses</b>	No statements, except fraudulent misstatements, made by You in the application for this Policy, shall be used to void this Policy or to deny a claim for loss incurred after 2 years from the Effective Date of this Policy. No claim for loss occurring after the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition had existed before the Effective Date of this Policy.
<b>Legal Action</b>	No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years after the time written Proof of Loss is required to be given.

**YOUR MEDICARE SUPPLEMENT POLICY**

If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.

If You have any questions about Your Policy, please write to Us and We will be happy to help You, or call Us, on Our toll free number listed above.

**Heartland National Life Insurance Company**  
**PO Box 2878**  
**Salt Lake City, Utah 84110-2878**

<p>Policy Benefits</p> <p>    Basic Benefits . . . . . Page 3</p> <p>        61st to 90th day</p> <p>        Lifetime Reserve</p> <p>        Following Lifetime Reserve</p> <p>        Part A &amp; B Blood</p> <p>        Part B Coinsurance</p> <p>    Additional Benefits (if any) . . . . . Page 3 &amp; 4</p> <p>Consideration . . . . . Page 1</p> <p>Coverage for Pre-existing Conditions . . . . . Page 1</p> <p>Definitions . . . . . Page 5</p> <p>    Benefit Period</p> <p>    Coinsurance</p> <p>    Confinement</p> <p>    Doctor</p> <p>    Hospital</p> <p>    Injury</p> <p>    Inpatient Hospital Deductible</p> <p>    Medicare</p> <p>    Medicare Part A</p> <p>    Medicare Part B</p> <p>    Medicare Eligible Expenses</p> <p>    Sickness</p> <p>Effective Date . . . . . Pages 1 &amp; 2</p>	<p>General Provisions . . . . . Pages 6 &amp; 7</p> <p>    Assignment</p> <p>    Claim Forms</p> <p>    Conformity with State Laws</p> <p>    Conservation Period</p> <p>    Continuation of Coverage</p> <p>    Electronic Claim Filing Process</p> <p>    Entire Contract; Changes</p> <p>    Grace Period</p> <p>    Legal Action</p> <p>    Misstatement of Age</p> <p>    Notice of Claim</p> <p>    Other Insurance with Us</p> <p>    Payment of Benefits</p> <p>    Proofs of Loss</p> <p>    Refund of Unearned Premium</p> <p>    Reinstatement</p> <p>    Time Limit on Certain Defenses</p> <p>    Timely Payment of Benefits</p> <p>    Unpaid Premium</p> <p>Individual Not Covered By Medicare . . . . . Page 5</p> <p>Limitations And Exclusions . . . . . Page 5</p> <p>Policy Suspension . . . . . Page 6</p> <p>Premium Changes . . . . . Page 1</p> <p>Renewal Conditions . . . . . Page 1</p> <p>Your Thirty Day Right to     Examine This Policy . . . . . Page 1</p>
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**YOU HAVE SELECTED PLAN F. THIS POLICY PROVIDES BENEFITS WHICH SUPPLEMENT MEDICARE. IT IS GUARANTEED RENEWABLE FOR YOUR LIFETIME. WE HAVE THE RIGHT TO CHANGE PREMIUMS ONLY ON A CLASS BASIS BY STATE.**

**Medicare Supplement Policy** We Insure You, named as the Insured on the Policy Schedule. We promise to pay the benefits provided in this Policy for covered losses that are incurred while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached. **Notice to Buyer: This Policy may not cover all of Your medical expenses.**

**Your Thirty Day Right to Examine This Policy** If for any reason You are not satisfied with this Policy, You may return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all premiums You paid to Us and then You and We will be in the same position as if a Policy had never been issued.

**Coverage for Pre-existing Conditions** Benefits will be paid for all covered losses under this Policy, even those caused by a Sickness, Injury or physical condition that existed before the Effective Date of the Policy. Loss occurring during a Confinement is considered to commence with the first day of such Confinement.

**Renewal Conditions** You may renew this Policy as long as You live. To renew, just pay a renewal premium. It must be paid on or before the end of the premium period, within the Grace Period, or during the Conservation Period. After this Policy is in force We cannot refuse to renew it or place any restrictions on it if the premium is paid on time.

**Premium Changes** We will not change the premiums for this Policy during Your first year of coverage within the {90000} Series. Thereafter, we can change them, but only if We change them for all policies like Yours in Your state on a class basis. A class is determined by benefits selected and year of issue. No rate adjustment may be made on an individual basis. Notice will be given to You at least 31 days before any premium change.

Your Policy benefits automatically change in accordance with Policy provisions whenever Medicare benefits change. After Your first year of coverage, the renewal premium for this Policy may change on a renewal date following the Effective Date of any change in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. Any such premium change will be based on the actuarial computations that We then use to determine the renewal premium.

**Consideration & Effective Date** This Policy is issued in consideration of the statements in Your application for insurance that is attached to and is made a part of this Policy, and the payment of the initial premium. This payment will keep the Policy in force until the first renewal date. The initial premium and the first renewal date are shown on Page 2. Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown on Page 2. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.

  
Secretary

  
President

**POLICY SCHEDULE**

Plan:

Policy Number:

Insured:

Effective Date:

First Renewal Date:

Initial Premium:

Endorsements:

**Renewal Premiums**

Annual

Semi-Annual

Quarterly

Monthly Bank Draft

*You have selected Plan F, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

- 61st to 90th Day Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.
- Lifetime Reserve Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.
- Following the Lifetime Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

- Part A & B Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

- Part B Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

## **ADDITIONAL BENEFITS**

- Medicare Part A Deductible** When You are confined as an inpatient to a Hospital, We will pay You the Medicare Part A Inpatient Hospital Deductible in any Medicare Benefit Period.
- Medicare Part B Deductible** We will pay You for all Eligible Expenses used to satisfy Your Medicare Part B deductible amount per calendar year regardless of Hospital Confinement.
- 100% of the Medicare Part B Excess Charges** We will pay You 100% of the difference between the actual Medicare Part B billed charge, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.
- Medically Necessary Emergency Care in a Foreign Country** When You are traveling outside the United States and require Emergency Care, we will pay You 80% of the billed charges after a calendar year deductible of \$250. Emergency Care shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset beginning during the first 60 consecutive days of each trip outside the United States. Medical services must be of the type that Medicare would have covered if the care had been received in the United States. This benefit is subject to a lifetime maximum of \$50,000 dollars.

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## DEFINITIONS

*The person named as the "Insured" on Page 2 of this Policy is referred to in this Policy as You, Your, Yours, or Insured and Heartland National Life Insurance Company as We, Our or Us.*

<b>Benefit Period</b>	Means a period that begins, after the Effective Date of this Policy, with the first day of Hospital Confinement and ends at the close of 60 consecutive days during which You were not confined to a Hospital or skilled nursing facility.
<b>Coinsurance</b>	Means the difference between the Medicare approved amount and the Medicare payment after You have satisfied the applicable Medicare deductibles.
<b>Confinement</b>	Means medically required stay as a resident inpatient in a Hospital or skilled nursing facility. It must be on the specific recommendation and under the general supervision of a Doctor.
<b>Doctor</b>	Means a duly licensed person practicing in the healing arts and acting within the scope of that license in treating a Sickness or Injury. A Doctor must be other than an immediate member of Your family.
<b>Hospital</b>	Means a place that is licensed as a Hospital pursuant to law and is legally operated for the care and treatment of sick or injured persons at their expense. A Hospital does not include the following kinds of facilities (including units in a Hospital used for such care); (a) convalescent, nursing home, rest home, or nursing care facilities; (b) places that primarily treat the aged, drug addicts or alcoholics; and (c) facilities that primarily provide custodial or educational care.
<b>Injury</b>	Means bodily harm sustained by You which: (a) is the direct result of an accident or trauma that occurs while Your Policy is in force; and (b) is not related to Sickness, bodily infirmity or any other cause.
<b>Inpatient Hospital Deductible</b>	Means the initial Hospital expense incurred during a Benefit Period for which You are responsible under Medicare.
<b>Medicare</b>	Means Title XVIII of the United States Social Security Act of 1965, as then constituted or later amended.
<b>Medicare Part A</b>	Means the program under Medicare officially called "Hospital Insurance Benefit for the Aged and Disabled".
<b>Medicare Part B</b>	Means the program under Medicare officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled".
<b>Medicare Eligible Expenses</b>	Means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
<b>Sickness</b>	Means illness or disease of an insured person.

## LIMITATIONS & EXCLUSIONS

<b>Limitations &amp; Exclusions</b>	We will not pay benefits under this Policy for: <ul style="list-style-type: none"><li>a) Any expense which is not eligible for payment under Medicare, unless otherwise covered in Your Policy or by optional endorsement; or</li><li>b) Any expense which You are not legally obligated to pay.</li></ul>
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## ELIGIBILITY FOR COVERAGE

<b>Individual Not Covered by Medicare</b>	If You have not established entitlement to benefits under Medicare, We will provide benefits under this Policy as though You had established entitlement.
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## POLICY SUSPENSION

<b>Medicaid Entitlement</b>	<p>If You apply for and become entitled to medical assistance under Medicaid, the benefits and premiums under Your Policy will be suspended, if requested, for up to 24 months during Your Medicaid Entitlement. You must request this suspension within 90 days of becoming entitled to Medicaid.</p> <p>If You lose Your entitlement to Medicaid while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Medicaid Entitlement and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Medicaid Entitlement is terminated.</p>
<b>Group Health Plan Coverage</b>	<p>If You were eligible for, and purchased this Policy by reason of disability and You become covered under an employer or union based group health plan, Your benefits and premiums under this Policy will be suspended, if requested, while You are covered under the group health plan.</p> <p>If You lose coverage under Your group health plan while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Group Health Plan Coverage and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Group Health Plan Coverage is terminated.</p>
<b>Reinstitution</b>	<p>Your reinstated Policy will provide the same or substantially equivalent coverage that was in effect when your Policy was suspended. The premium for Your reinstated Policy will be on the same terms that would have applied had Your Policy not been suspended.</p>

## GENERAL PROVISIONS

<b>Entire Contract; Changes</b>	<p>This Policy with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.</p>
<b><u>Conformity with State Laws</u></b>	<p><u>Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that Effective Date is amended to conform to the minimum requirements of such laws.</u></p>
<b><u>Notice of Claim</u></b>	<p><u>Written Notice of Claim must be given within 6 months after a covered loss begins or as soon as possible. The notice can be given to Us at the address shown on Page 8, or to any one of Our agents. The notice should include Your name and Policy number.</u></p>
<b>Claim Forms</b>	<p>When We receive Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not sent to You within 15 days after giving such notice, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.</p>
<b>Electronic Claim Filing Process</b>	<p>Your health care providers will usually submit electronically to Medicare the billed charges for any medical or Hospital expenses You incur. Medicare then processes the benefits for expenses eligible under Part A and/or B, and then passes Your claim electronically to Us for consideration of benefits under Your Policy. We will accept Medicare's electronic submission of Your claim to Us as Your Notice of Claim and Your Claim Form. For consideration of expenses that are not submitted electronically to Us, a paper copy of Your Medicare Summary Notice can serve as Your Notice of Claim and Claim Form. The Medicare Summary Notice shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare Summary Notice to Us or Your health care provider may submit it to Us on Your behalf.</p>
<b>Proofs of Loss</b>	<p>Written Proof of Loss must be given to Us within 90 days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.</p>

<b>Payment of Benefits</b>	All benefits will be paid to You, or Your assignee. Benefits unpaid at Your death may be paid to Your estate or We may pay up to \$1,000 to any relative of Yours who is entitled to them. Any payment made in good faith will fully release Us to the extent of that payment.
<b>Timely Payment of Benefits</b>	Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.
<b>Assignment</b>	No assignment of benefits under this Policy shall be binding upon Us unless the original (or copy of it) is on file with Us. We do not assume any responsibility for the validity of any assignment.
<b>Other Insurance With Us</b>	Your insurance under a like policy or policies with Us is limited to one such policy elected by You, Your beneficiary or Your estate, as the case may be, and We will return all premiums paid for all such other policies.
<b>Grace Period</b>	This Policy has a 31 day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period this Policy will stay in force.
<b>Conservation Period</b>	We offer You an additional 15 days beyond the Grace Period to pay Your premium. During this 15 day extension, this Policy is not in force unless Your premium is paid within this period. The Policy will then be renewed with no lapse in coverage.
<b>Unpaid Premium</b>	We reserve the right to deduct any premium due and unpaid from a claim payment.
<b>Reinstatement</b>	<p>If the renewal premium is not paid before the Grace Period ends or within the Conservation Period, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for Reinstatement will Reinstatement this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be Reinstated as of the approval date. Lacking such approval this Policy will be Reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.</p> <p>The Reinstated Policy will only cover losses that result from Injury or Sickness sustained after the date of Reinstatement. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any premium accepted with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.</p>
<b>Continuation of Coverage</b>	We cannot terminate Your Policy as long as You pay Your premium on time. Termination of coverage under this Policy shall be without prejudice to any continuous loss for Confinement to a Hospital or skilled nursing facility that commences while this Policy is in force and during which You are determined to be continuously totally disabled. In this Policy, "continuously totally disabled" means the complete inability of a person to engage in all the normal activities of a person of the same age and gender.
<b>Refund of Unearned Premium</b>	We will refund that part of any premium paid which covers a period beyond the end of the Policy month of Your death.
<b>Time Limit on Certain Defenses</b>	No statements, except fraudulent misstatements, made by You in the application for this Policy, shall be used to void this Policy or to deny a claim for loss incurred after 2 years from the Effective Date of this Policy. No claim for loss occurring after the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition had existed before the Effective Date of this Policy.
<b>Legal Action</b>	No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years after the time written Proof of Loss is required to be given.

**YOUR MEDICARE SUPPLEMENT POLICY**

If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.

If You have any questions about Your Policy, please write to Us and We will be happy to help You, or call Us, on Our toll free number listed above.

**Heartland National Life Insurance Company**  
**PO Box 2878**  
**Salt Lake City, Utah 84110-2878**

<p>Policy Benefits</p> <p>  Basic Benefits ..... Page 3</p> <p>    61st to 90th day</p> <p>    Lifetime Reserve</p> <p>    Following Lifetime Reserve</p> <p>    Part A &amp; B Blood</p> <p>    Part B Coinsurance</p> <p>  Additional Benefits (if any) ..... Page 3 &amp; 4</p> <p>Consideration ..... Page 1</p> <p>Coverage for Pre-existing Conditions ..... Page 1</p> <p>Definitions ..... Page 5</p> <p>  Benefit Period</p> <p>  Coinsurance</p> <p>  Confinement</p> <p>  Doctor</p> <p>  Hospital</p> <p>  Injury</p> <p>  Inpatient Hospital Deductible</p> <p>  Medicare</p> <p>  Medicare Part A</p> <p>  Medicare Part B</p> <p>  Medicare Eligible Expenses</p> <p>  Sickness</p> <p>Effective Date ..... Pages 1 &amp; 2</p>	<p>General Provisions ..... Pages 6 &amp; 7</p> <p>  Assignment</p> <p>  Claim Forms</p> <p>  Conformity with State Laws</p> <p>  Conservation Period</p> <p>  Continuation of Coverage</p> <p>  Electronic Claim Filing Process</p> <p>  Entire Contract; Changes</p> <p>  Grace Period</p> <p>  Legal Action</p> <p>  Misstatement of Age</p> <p>  Notice of Claim</p> <p>  Other Insurance with Us</p> <p>  Payment of Benefits</p> <p>  Proofs of Loss</p> <p>  Refund of Unearned Premium</p> <p>  Reinstatement</p> <p>  Time Limit on Certain Defenses</p> <p>  Timely Payment of Benefits</p> <p>  Unpaid Premium</p> <p>Individual Not Covered By Medicare ..... Page 5</p> <p>Limitations And Exclusions ..... Page 5</p> <p>Policy Suspension ..... Page 6</p> <p>Premium Changes ..... Page 1</p> <p>Renewal Conditions ..... Page 1</p> <p>Your Thirty Day Right to   Examine This Policy ..... Page 1</p>
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**YOU HAVE SELECTED PLAN G. THIS POLICY PROVIDES BENEFITS WHICH SUPPLEMENT MEDICARE. IT IS GUARANTEED RENEWABLE FOR YOUR LIFETIME. WE HAVE THE RIGHT TO CHANGE PREMIUMS ONLY ON A CLASS BASIS BY STATE.**

**Medicare Supplement Policy** We Insure You, named as the Insured on the Policy Schedule. We promise to pay the benefits provided in this Policy for covered losses that are incurred while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached. **Notice to Buyer: This Policy may not cover all of Your medical expenses.**

**Your Thirty Day Right to Examine This Policy** If for any reason You are not satisfied with this Policy, You may return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all premiums You paid to Us and then You and We will be in the same position as if a Policy had never been issued.

**Coverage for Pre-existing Conditions** Benefits will be paid for all covered losses under this Policy, even those caused by a Sickness, Injury or physical condition that existed before the Effective Date of the Policy. Loss occurring during a Confinement is considered to commence with the first day of such Confinement.

**Renewal Conditions** You may renew this Policy as long as You live. To renew, just pay a renewal premium. It must be paid on or before the end of the premium period, within the Grace Period, or during the Conservation Period. After this Policy is in force We cannot refuse to renew it or place any restrictions on it if the premium is paid on time.

**Premium Changes** We will not change the premiums for this Policy during Your first year of coverage within the 90000 Series. Thereafter, we can change them, but only if We change them for all policies like Yours in Your state on a class basis. A class is determined by benefits selected and year of issue. No rate adjustment may be made on an individual basis. Notice will be given to You at least 31 days before any premium change.

Your Policy benefits automatically change in accordance with Policy provisions whenever Medicare benefits change. After Your first year of coverage, the renewal premium for this Policy may change on a renewal date following the Effective Date of any change in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. Any such premium change will be based on the actuarial computations that We then use to determine the renewal premium.

**Consideration & Effective Date** This Policy is issued in consideration of the statements in Your application for insurance that is attached to and is made a part of this Policy, and the payment of the initial premium. This payment will keep the Policy in force until the first renewal date. The initial premium and the first renewal date are shown on Page 2. Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown on Page 2. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.

  
Secretary

  
President

**POLICY SCHEDULE**

Plan:

Policy Number:

Insured:

Effective Date:

First Renewal Date:

Initial Premium:

Endorsements:

**Renewal Premiums**

Annual

Semi-Annual

Quarterly

Monthly Bank Draft

*You have selected Plan G, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

- 61st to 90th Day Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.
- Lifetime Reserve Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.
- Following the Lifetime Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

- Part A & B Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

- Part B Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

## **ADDITIONAL BENEFITS**

- Medicare Part A Deductible** When You are confined as an inpatient to a Hospital, We will pay You the Medicare Part A Inpatient Hospital Deductible in any Medicare Benefit Period.
- Skilled Nursing Facility Benefit** We will pay You the actual billed charges up to the daily Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital skilled nursing facility care eligible under Medicare Part A.
- 80% of the Medicare Part B Excess Charges** We will pay You 80% of the difference between the actual Medicare Part B billed charge, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.
- Medically Necessary Emergency Care in a Foreign Country** When You are traveling outside the United States and require Emergency Care, we will pay You 80% of the billed charges after a calendar year deductible of \$250. Emergency Care shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset beginning during the first 60 consecutive days of each trip outside the United States. Medical services must be of the type that Medicare would have covered if the care had been received in the United States. This benefit is subject to a lifetime maximum of \$50,000 dollars.

**Benefits are continued on Page 4**

### ADDITIONAL BENEFITS (continued)

#### **At-Home Recovery Benefit**

We will pay You the actual charge, up to \$40 dollars per visit, for short term assistance with Activities of Daily Living furnished in Your Home by a Care Provider when you are recovering from a Sickness, Injury or surgery. You may receive up to 7 visits per week, with a calendar year maximum of 40 visits or \$1,600 dollars.

To receive benefits, Your Doctor must certify that the type and frequency of At-Home Recovery Visits are necessary because of a condition for which Your home care plan of treatment was approved by Medicare. All visits must be received during the period in which You are receiving Medicare approved home health care services, or within 8 weeks of the last date of service of a Medicare approved home health visit. In no event shall the total number of At-Home Recovery Visits exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

For purposes of this benefit, the following definitions shall apply:

(i) "Activities of Daily Living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings. (ii) "Care Provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry. (iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A Hospital or skilled nursing facility shall not be considered the insured's place of residence. (iv) "At-Home Recovery Visit" means the period of a visit required to provide At-Home Recovery Care, without limit on the duration of the visit, except each consecutive 4 hours in a 24 hour period of services provided by a Care Provider is one visit.

Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and (ii) care provided by family members, unpaid volunteers or providers who are not Care Providers.

## DEFINITIONS

*The person named as the "Insured" on Page 2 of this Policy is referred to in this Policy as You, Your, Yours, or Insured and Heartland National Life Insurance Company as We, Our or Us.*

<b>Benefit Period</b>	Means a period that begins, after the Effective Date of this Policy, with the first day of Hospital Confinement and ends at the close of 60 consecutive days during which You were not confined to a Hospital or skilled nursing facility.
<b>Coinsurance</b>	Means the difference between the Medicare approved amount and the Medicare payment after You have satisfied the applicable Medicare deductibles.
<b>Confinement</b>	Means medically required stay as a resident inpatient in a Hospital or skilled nursing facility. It must be on the specific recommendation and under the general supervision of a Doctor.
<b>Doctor</b>	Means a duly licensed person practicing in the healing arts and acting within the scope of that license in treating a Sickness or Injury. A Doctor must be other than an immediate member of Your family.
<b>Hospital</b>	Means a place that is licensed as a Hospital pursuant to law and is legally operated for the care and treatment of sick or injured persons at their expense. A Hospital does not include the following kinds of facilities (including units in a Hospital used for such care); (a) convalescent, nursing home, rest home, or nursing care facilities; (b) places that primarily treat the aged, drug addicts or alcoholics; and (c) facilities that primarily provide custodial or educational care.
<b>Injury</b>	Means bodily harm sustained by You which: (a) is the direct result of an accident or trauma that occurs while Your Policy is in force; and (b) is not related to Sickness, bodily infirmity or any other cause.
<b>Inpatient Hospital Deductible</b>	Means the initial Hospital expense incurred during a Benefit Period for which You are responsible under Medicare.
<b>Medicare</b>	Means Title XVIII of the United States Social Security Act of 1965, as then constituted or later amended.
<b>Medicare Part A</b>	Means the program under Medicare officially called "Hospital Insurance Benefit for the Aged and Disabled".
<b>Medicare Part B</b>	Means the program under Medicare officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled".
<b>Medicare Eligible Expenses</b>	Means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
<b>Sickness</b>	Means illness or disease of an insured person.

## LIMITATIONS & EXCLUSIONS

<b>Limitations &amp; Exclusions</b>	We will not pay benefits under this Policy for: <ul style="list-style-type: none"><li>a) Any expense which is not eligible for payment under Medicare, unless otherwise covered in Your Policy or by optional endorsement; or</li><li>b) Any expense which You are not legally obligated to pay.</li></ul>
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## ELIGIBILITY FOR COVERAGE

<b>Individual Not Covered by Medicare</b>	If You have not established entitlement to benefits under Medicare, We will provide benefits under this Policy as though You had established entitlement.
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## POLICY SUSPENSION

<b>Medicaid Entitlement</b>	<p>If You apply for and become entitled to medical assistance under Medicaid, the benefits and premiums under Your Policy will be suspended, if requested, for up to 24 months during Your Medicaid Entitlement. You must request this suspension within 90 days of becoming entitled to Medicaid.</p> <p>If You lose Your entitlement to Medicaid while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Medicaid Entitlement and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Medicaid Entitlement is terminated.</p>
<b>Group Health Plan Coverage</b>	<p>If You were eligible for, and purchased this Policy by reason of disability and You become covered under an employer or union based group health plan, Your benefits and premiums under this Policy will be suspended, if requested, while You are covered under the group health plan.</p> <p>If You lose coverage under Your group health plan while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Group Health Plan Coverage and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Group Health Plan Coverage is terminated.</p>
<b>Reinstitution</b>	<p>Your reinstated Policy will provide the same or substantially equivalent coverage that was in effect when your Policy was suspended. The premium for Your reinstated Policy will be on the same terms that would have applied had Your Policy not been suspended.</p>

## GENERAL PROVISIONS

<b>Entire Contract; Changes</b>	<p>This Policy with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.</p>
<b><u>Conformity with State Laws</u></b>	<p><u>Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that Effective Date is amended to conform to the minimum requirements of such laws.</u></p>
<b><u>Notice of Claim</u></b>	<p><u>Written Notice of Claim must be given within 6 months after a covered loss begins or as soon as possible. The notice can be given to Us at the address shown on Page 8, or to any one of Our agents. The notice should include Your name and Policy number.</u></p>
<b>Claim Forms</b>	<p>When We receive Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not sent to You within 15 days after giving such notice, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.</p>
<b>Electronic Claim Filing Process</b>	<p>Your health care providers will usually submit electronically to Medicare the billed charges for any medical or Hospital expenses You incur. Medicare then processes the benefits for expenses eligible under Part A and/or B, and then passes Your claim electronically to Us for consideration of benefits under Your Policy. We will accept Medicare's electronic submission of Your claim to Us as Your Notice of Claim and Your Claim Form. For consideration of expenses that are not submitted electronically to Us, a paper copy of Your Medicare Summary Notice can serve as Your Notice of Claim and Claim Form. The Medicare Summary Notice shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare Summary Notice to Us or Your health care provider may submit it to Us on Your behalf.</p>
<b>Proofs of Loss</b>	<p>Written Proof of Loss must be given to Us within 90 days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.</p>

<b>Payment of Benefits</b>	All benefits will be paid to You, or Your assignee. Benefits unpaid at Your death may be paid to Your estate or We may pay up to \$1,000 to any relative of Yours who is entitled to them. Any payment made in good faith will fully release Us to the extent of that payment.
<b>Timely Payment of Benefits</b>	Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.
<b>Assignment</b>	No assignment of benefits under this Policy shall be binding upon Us unless the original (or copy of it) is on file with Us. We do not assume any responsibility for the validity of any assignment.
<b>Other Insurance With Us</b>	Your insurance under a like policy or policies with Us is limited to one such policy elected by You, Your beneficiary or Your estate, as the case may be, and We will return all premiums paid for all such other policies.
<b>Grace Period</b>	This Policy has a 31 day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period this Policy will stay in force.
<b>Conservation Period</b>	We offer You an additional 15 days beyond the Grace Period to pay Your premium. During this 15 day extension, this Policy is not in force unless Your premium is paid within this period. The Policy will then be renewed with no lapse in coverage.
<b>Unpaid Premium</b>	We reserve the right to deduct any premium due and unpaid from a claim payment.
<b>Reinstatement</b>	<p>If the renewal premium is not paid before the Grace Period ends or within the Conservation Period, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for Reinstatement will Reinstatement this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be Reinstated as of the approval date. Lacking such approval this Policy will be Reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.</p> <p>The Reinstated Policy will only cover losses that result from Injury or Sickness sustained after the date of Reinstatement. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any premium accepted with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.</p>
<b>Continuation of Coverage</b>	We cannot terminate Your Policy as long as You pay Your premium on time. Termination of coverage under this Policy shall be without prejudice to any continuous loss for Confinement to a Hospital or skilled nursing facility that commences while this Policy is in force and during which You are determined to be continuously totally disabled. In this Policy, "continuously totally disabled" means the complete inability of a person to engage in all the normal activities of a person of the same age and gender.
<b>Refund of Unearned Premium</b>	We will refund that part of any premium paid which covers a period beyond the end of the Policy month of Your death.
<b>Time Limit on Certain Defenses</b>	No statements, except fraudulent misstatements, made by You in the application for this Policy, shall be used to void this Policy or to deny a claim for loss incurred after 2 years from the Effective Date of this Policy. No claim for loss occurring after the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition had existed before the Effective Date of this Policy.
<b>Legal Action</b>	No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years after the time written Proof of Loss is required to be given.

**YOUR MEDICARE SUPPLEMENT POLICY**

If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.

If You have any questions about Your Policy, please write to Us and We will be happy to help You, or call Us, on Our toll free number listed above.

**Heartland National Life Insurance Company**  
**PO Box 2878**  
**Salt Lake City, Utah 84110-2878**

<p>Policy Benefits</p> <p style="padding-left: 20px;">Basic Benefits ..... Page 3</p> <p style="padding-left: 40px;">61st to 90th day</p> <p style="padding-left: 40px;">Lifetime Reserve</p> <p style="padding-left: 40px;">Following Lifetime Reserve</p> <p style="padding-left: 40px;">Part A &amp; B Blood</p> <p style="padding-left: 40px;">Part B Coinsurance</p> <p style="padding-left: 20px;">Additional Benefits (if any) ..... Page 3 &amp; 4</p> <p>Consideration ..... Page 1</p> <p>Coverage for Pre-existing Conditions ..... Page 1</p> <p>Definitions ..... Page 5</p> <p style="padding-left: 20px;">Benefit Period</p> <p style="padding-left: 20px;">Coinsurance</p> <p style="padding-left: 20px;">Confinement</p> <p style="padding-left: 20px;">Doctor</p> <p style="padding-left: 20px;">Hospital</p> <p style="padding-left: 20px;">Injury</p> <p style="padding-left: 20px;">Inpatient Hospital Deductible</p> <p style="padding-left: 20px;">Medicare</p> <p style="padding-left: 20px;">Medicare Part A</p> <p style="padding-left: 20px;">Medicare Part B</p> <p style="padding-left: 20px;">Medicare Eligible Expenses</p> <p style="padding-left: 20px;">Sickness</p> <p>Effective Date ..... Pages 1 &amp; 2</p>	<p>General Provisions ..... Pages 6 &amp; 7</p> <p style="padding-left: 20px;">Assignment</p> <p style="padding-left: 20px;">Claim Forms</p> <p style="padding-left: 20px;">Conformity with State Laws</p> <p style="padding-left: 20px;">Conservation Period</p> <p style="padding-left: 20px;">Continuation of Coverage</p> <p style="padding-left: 20px;">Electronic Claim Filing Process</p> <p style="padding-left: 20px;">Entire Contract; Changes</p> <p style="padding-left: 20px;">Grace Period</p> <p style="padding-left: 20px;">Legal Action</p> <p style="padding-left: 20px;">Misstatement of Age</p> <p style="padding-left: 20px;">Notice of Claim</p> <p style="padding-left: 20px;">Other Insurance with Us</p> <p style="padding-left: 20px;">Payment of Benefits</p> <p style="padding-left: 20px;">Proofs of Loss</p> <p style="padding-left: 20px;">Refund of Unearned Premium</p> <p style="padding-left: 20px;">Reinstatement</p> <p style="padding-left: 20px;">Time Limit on Certain Defenses</p> <p style="padding-left: 20px;">Timely Payment of Benefits</p> <p style="padding-left: 20px;">Unpaid Premium</p> <p>Individual Not Covered By Medicare ..... Page 5</p> <p>Limitations And Exclusions ..... Page 5</p> <p>Policy Suspension ..... Page 6</p> <p>Premium Changes ..... Page 1</p> <p>Renewal Conditions ..... Page 1</p> <p>Your Thirty Day Right to Examine This Policy ..... Page 1</p>
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**PART I - MEDICARE & INSURANCE INFORMATION (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. Did you turn age 65 in the last six months?  Yes  No
- 2. Did you enroll in Medicare Part B in the last six months?  Yes  No

If "Yes", what is the effective date? --

- 3. 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

- 4. 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. (If you are still covered under the other policy, leave "END" blank.)

Start -- End --

- b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?  Yes  No
- c. Was this your first time in this type of Medicare plan?  Yes  No
- d. Did you drop a Medicare Supplement plan to enroll in the Medicare plan?  Yes  No

- 5. 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

- 6. 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 and what kind of policy?

b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

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 1-8 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 benefits; or 2) is primary to Medicare and the plan terminates or the plan ceases to provide all 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 circumstance 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, 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, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then the insured person terminates coverage within 12 months or enrollment; or

- f. Upon first becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage or PACE provider and then disenrolled within 12 months
- g. Terminated coverage under a Medicare Supplement policy that covers outpatient prescription drugs and enrolled in a Medicare Part D plan during the initial enrollment period.

**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

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 premiums 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.

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

**Fraud 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:   -   -      
(Month/Day/Year)

Applicant's Signature: \_\_\_\_\_

Writing Agent's Signature: \_\_\_\_\_

Agent Number:

Mail policy to  Agent  Applicant

**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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 #1 Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent #2 Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent #1 Name (please print) \_\_\_\_\_ Agent # \_\_\_\_\_ Split % \_\_\_\_\_  
[Grid of boxes for name, agent number, and split percentage]

Agent #2 Name (please print) \_\_\_\_\_ Agent # \_\_\_\_\_ Split % \_\_\_\_\_  
[Grid of boxes for name, agent number, and split percentage]

## HEALTH QUESTIONS

**Do not answer health questions 1-9 if you are in open enrollment or a guaranteed issued period. Please see page three for an explanation of open enrollment/guaranteed issue period information.**

**If You Answer “YES” to any part of questions 1-6 you are not eligible for coverage.**

**NOTICE TO APPLICANT: Please verify the accuracy and completeness of the medical information on this application. In complete or false information on this application could jeopardize future claims.**

- 1.) Have you been hospitalized, confined to a nursing facility or received home health care within the past 60 days or been hospitalized 3 or more times in the past 2 years?  Yes  No
- 2.) 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
- 3.) In the past two years, have you been advised by a physician or other member of the medical profession to have surgery, medical tests, or an organ transplant that has not been performed?  Yes  No
- 4.) Have you been advised by a physician or other member of the medical profession that you need to have surgery performed within the next twelve months?  Yes  No
- 5.) Do you have now, or during the past five years have you received medical treatment, or been medically advised to have treatment, surgery or taken medication for any of the following conditions:
  - a. Parkinson’s Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Alzheimer’s Disease or dementia?  Yes  No
  - b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV)?  Yes  No
  - c. Insulin Dependent Diabetes, uncontrolled diabetes or diabetes with complications such as retinopathy, neuropathy or kidney problems?  Yes  No
  - d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any chronic pulmonary condition requiring the use of oxygen?  Yes  No
  - e. Internal Cancer, Leukemia, malignant melanoma, Hodgkins Disease or Lymphoma?  Yes  No
  - f. Osteoporosis with related fractures?  Yes  No
  - g. Any kidney disease requiring dialysis?  Yes  No
- 6.) Within the past 2 years have you had, been medically treated for, or has treatment been recommended by a physician or other member of the medical profession for:
  - a. Heart surgery, congestive heart failure, heart attack, peripheral vascular disease, arrhythmia, stroke, or transient ischemic attack (TIA)?  Yes  No
  - b. Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse?  Yes  No
  - c. Amputation caused by disease?  Yes  No
  - d. Mental or nervous disorder requiring psychiatric care?  Yes  No
  - e. Disabling, crippling or rheumatoid arthritis?  Yes  No
- 7.) Do you require the use of a wheelchair?  Yes  No

**Additional Questions:**

- 8.) Have you used tobacco in any form in the last 2 years?  Yes  No
- 9.) Are you taking or have you taken any prescription drugs or over the counter medications within the past 12 months?  Yes  No  
If, Yes, please list the drug and the reason prescribed below.

Prescription Name	Reason Prescribed

**DOCTOR YOU USUALLY CONSULT - Your Primary Care Physician**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

# Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided services, treatment or payment to me, or on my behalf, within the past 10 years ("My Providers"), or consumer reporting agency, or the Medical Information Bureau, to disclose my entire medical record and any other protected health information concerning me to Heartland National Life Insurance Company ("Heartland") and its agents, employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

**My protected health information is to be disclosed under this Authorization so that Heartland may:** 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill their responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Heartland.

For a period of 120 days from the date of this Authorization I authorize my Heartland Agent to receive certain protected health information about me that is related to an adverse underwriting decision or counteroffer for alternative coverage made during the underwriting of my application.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to: **Heartland National Life Insurance Company at PO Box 2878, Salt Lake City, Utah 84110-2878, Attention: Privacy Officer.** I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Heartland has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Heartland may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

\_\_\_\_\_  
Name of Applicant (please print)

\_\_\_\_\_  
Signature of Applicant or Personal Representative

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority or Relationship to Applicant (if applicable)

HHA (04)

(Return to Company)

\*2020000901\*

**NOTICE TO APPLICANTS REGARDING REPLACEMENT  
OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE**

HEARTLAND NATIONAL LIFE INSURANCE COMPANY  
PO BOX 2878, Salt Lake City, UT 84110-2878

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!**

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage coverage and replace it with a policy to be issued by Heartland National Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your policy or Medicare Advantage coverage only if after due consideration and acceptance by the replacing insurer, you find that purchase of this Medicare Supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

**STATEMENT TO APPLICANT BY AGENT:** I have reviewed your current medical or health insurance coverage. To the best of my knowledge this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.  Same benefits, but lower premium.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

Other (please specify). \_\_\_\_\_

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

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

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Producers PRINTED name and address

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

*Producer: If this replacement notice is necessary, have the insured complete and sign this form and leave it with the Applicant.*

**NOTICE TO APPLICANTS REGARDING REPLACEMENT  
OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE**

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

PO BOX 2878, Salt Lake City, UT 84110-2878

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- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

Other (please specify). \_\_\_\_\_  
\_\_\_\_\_

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

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

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Producers PRINTED name and address

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

*Producer: If this replacement notice is necessary, have the insured complete and sign this form and return it to us with all other forms.*

HRN-07

Return to Company

\*90000002001\*

## NOTICE OF OUR INFORMATION PRACTICES AND PRIVACY POLICY

With your application for insurance we receive personal information about you. You also authorized us to collect your health information. We keep and protect all such information as confidential and do not disclose it to any other persons, entities or organizations unless authorized by you in writing or as allowed or required by law. "We" or "Our" is defined as Heartland National Life Insurance Company and its Third Party Administrator (TPA), Equitable Life & Casualty Insurance Company.

### Information We Collect And Receive

Personal information we receive about you comes directly from you, such as your name, address, birth date, Social Security number, telephone number, or e-mail address. Health (medical) information about you comes from you and your health care providers (doctors, clinics, hospitals, laboratories, etc.) based on your written Authorization. We may also review information about you on file with the MIB Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members.

### What We Do With This Information

Your personal information is entered in our system to identify you as our customer. Other uses of your personal and health information include underwriting your application for insurance and assisting you in a claim for benefits. Your Heartland agent, as our business associate, may have access to your health information during the underwriting process, as authorized by you, and access to your personal information for assistance with your insurance needs.

Under our established procedures, if upon the consideration of your medical information we determine you do not meet our underwriting guidelines for the issuance of a policy, the medical reason(s) for a declination of coverage may be disclosed to the person or entity (usually your doctor) who maintains your medical information. Your doctor can then discuss with you, through a private consultation, the medical reason(s) for our decision.

### How We Protect This Information

Our employees and agents are required to keep your personal and health information confidential. Our intention is to request or access only the minimum amount of information necessary. We maintain all your personal or health information in a secured database, with security and procedural measures in place, in compliance with federal law, to safeguard your protected information and alert us if and when unauthorized access is attempted.

We do not disclose your personal or health information with any nonaffiliated third party (person, entity or organization) without your written permission, unless allowed or required by law. Under no circumstances will any information be disclosed to any nonaffiliated party for marketing purposes, such as telemarketing, direct mail or electronic mail marketing.

### How You Can Access This Information

Write to us and request copies of the personal information we have about you in our records. You can also find out who we have disclosed this information to and for what reason. If you believe any personal or health information we have about you is incomplete, inaccurate or incorrect, you have the right to request that we correct or delete it. If your request concerns health information we received from a doctor, hospital or other medical provider, we will refer you to that person or entity. You may, in a private consultation with them, have the necessary corrections made to your health information and sent to us.

### The MIB Inc.

Information regarding your insurability will be treated as confidential. Heartland National Life Insurance Company, its TPA, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB, toll free, at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Heartland National Life Insurance Company, its TPA, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

If you have any questions about this Notice, we can be contacted at:

**Heartland National Life Insurance Company**  
**PO Box 2878, Salt Lake City, UT 84110-2878**  
**ATTN: Privacy Officer**  
Telephone (toll free): 1-866-916-7971

**Leave with Applicant**

Receipt

**Receipt**

*Please Note: All premium checks must be made payable to Heartland National Life Insurance Company.  
Do not make checks payable to the insurance agent or leave the payee line blank.*

Received from \_\_\_\_\_ the sum  
of \$\_\_\_\_\_ for \_\_\_\_\_ months premium, with this application. If for any rea-  
son the application is not approved and the policy is not issued, this premium is to be refunded. No li-  
ability is created or assumed by the Company, except for refund of this premium, until the policy applied  
for has been issued.

Date Receipt and Outline of Coverage was prepared \_\_\_\_\_, 20 \_\_\_\_\_

by \_\_\_\_\_  
*Agent's Signature*

Heartland National Life Insurance Company, PO Box 2878, Salt Lake City, UT 84110-2878

**Heartland National Life Insurance Company**  
**Outline Of Medicare Supplement Coverage - Cover Page: 1 of 2**  
**Benefit Plans A, D, F and G**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

**Basic Benefits For Plans A-J:** Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end; Medical Expenses - Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services; Blood - First three pints of blood each year.

A	B	C	D	E	F	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
	Part B Deductible	Part B Deductible			Part B Deductible				Part B Deductible	Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)			Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
				Preventive Care NOT Covered by Medicare						Preventive Care NOT Covered by Medicare

❖ Plans currently not available for sale

\* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year \$2,000 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

**Heartland National Life Insurance Company**  
**Outline Of Medicare Supplement Coverage - Cover Page: 2 of 2**

**Basic Benefits for Plans K and L:** Similar services as plans A - J, but cost sharing for the basic benefits is at different levels.

J❖	K**❖	L**❖
Basic Benefits	100% of Part A Hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 50% Hospice cost-sharing 50% of Medicare eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B Preventive Services	100% of Part A Hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 75% Hospice cost-sharing 75% of Medicare eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	\$[4,620] Out-of-Pocket Annual Limit***	\$[2,310] Out-of-Pocket Annual Limit***

❖ Plans currently not available for sale

\*\* Plans K and L provide for different cost-sharing for items and services than Plans A – J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges.” You will be responsible for paying excess charges.

\*\*\* The out-of-pocket annual limit will increase each year for inflation.

See the following Plan descriptions for details and exceptions.

**Preferred Premiums - Annual**  
**Zip Codes: 720-722**

	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65+	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90

*Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12*

**Preferred Premiums - Annual**

**Zip Codes: 716-719, 723-729**

	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65+	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00

*Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12*

**Standard Premiums - Annual**

**Zip Codes: 720-722**

	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65+	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30

*Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12*

**Standard Premiums - Annual**

**Zip Codes: 716-719, 723-729**

	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65+	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70

*Modal Factors: SA = Annual x.5, Q = Annual x.25, MBD= Annual ÷ 12*

**PREMIUM INFORMATION**

We, Heartland National Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State. Each year following the changes in Medicare's deductibles and/or benefits your rates may be adjusted at that time. Your initial premiums are guaranteed for one full year.

**DISCLOSURE PAGE**

Use this outline to compare benefits and premiums among policies.

**READ YOUR POLICY VERY CAREFULLY**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

**RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to us at: PO Box 2878, Salt Lake City, Utah 84110-2878. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued, and return all of your payments.

**POLICY REPLACEMENT**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

**NOTICE**

This policy may not fully cover all of your medical costs. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

Neither Heartland National Life nor its agents are connected with Medicare.

**COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**PLAN A**  
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day  91st day and after: -While using 60 lifetime reserve days  -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but [\$1068]  All but [\$267] a day  All but [\$534] a day  \$0  \$0	\$0  [\$267] a day  [\$534] a day  100% of Medicare eligible expenses \$0	[\$1068] (Part A deductible)  \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$133.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**Plan A (continued)**  
**MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR**

*\*\*Once you have been billed [\$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT,</b> such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$131] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$135] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next [\$131] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$135] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Part A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [\$131] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$135] (Part B Deductible) \$0
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**PLAN D**  
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but [\$1068]  All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses \$0	\$0  \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

**MEDICARE (Part B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*\* Once you have been billed [\$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b> such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$135] of Medicare Approved Amounts ** Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$135] (Part B Deductible) \$0

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**Plan D (continued)**

<b>SERVICES (Medicare Part B, cont'd)</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next [\$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$135] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Part A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [\$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	100%   \$0 80%	\$0   \$0 20%	\$0   [\$135] (Part B Deductible) \$0
<b>AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan -Benefit for each visit -Number of visits covered (must be received within 8 weeks of last Medicare Approved Visit) -Calendar Year Maximum	\$0  \$0  \$0	Actual charges to \$40 a visit. Up to the number of Medicare Approved visits, not to exceed 7 each week  \$1600	Balance  Balance  Balance

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE,</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**PLAN F**  
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days  -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but [\$1068] All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses \$0	\$0 \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints  Additional amounts	\$0  100%	3 pints  \$0	\$0  \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**Plan F (continued)**  
**MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR**

*\*\*Once you have been billed [\$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 Generally 80%	[\$135] (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs [\$135] (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Part A & B**

<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b> -Medically necessary skilled care services and medical supplies -Durable medical equipment First [\$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 [\$135] (Part B Deductible) 20%	\$0 \$0 \$0
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**Other Benefits - Not Covered by Medicare**

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> , Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**PLAN G**  
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but [\$1068] All but [\$267] a day All but [\$534] a day  \$0 \$0	[\$1068] (Part A deductible) [\$267] a day [\$534] a day  100% of Medicare eligible expenses \$0	\$0 \$0 \$0  \$0*** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

**MEDICARE (Part B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*\* Once you have been billed [\$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b> such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$135] of Medicare Approved Amounts ** Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$135] (Part B Deductible) \$0

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**Plan G (continued)**

<b>SERVICES (Medicare Part B, cont'd)</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
Part B excess Charges (Above Medicare Approved Amounts)	\$0	80%	20%
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next [\$135] of Medicare Approved Amounts**	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Part A & B**

<b>HOME HEALTH CARE</b>			
<b>MEDICARE APPROVED SERVICES</b>			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First [\$135] of Medicare Approved Amounts**	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</b>			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	\$0	Actual charges to \$40 a visit.	Balance
-Number of visits covered (must be received with- in 8 weeks of last Medicare Approved Visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	Balance
-Calendar Year Maximum	\$0	\$1,600	Balance

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> , Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum



HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: Indiana

Medicare Supplement Administrative Office: PO Box 2878, Salt Lake City, UT 84110-2878

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

<p><b>Applicant Last</b>  <input type="text"/></p> <p><b>First</b> <span style="float:right"><b>MI</b></span>  <input type="text"/> <input type="text"/></p>	<p><b>Residence Address: Street:</b>  <input type="text"/></p> <p><b>City:</b>  <input type="text"/></p> <p><b>State:</b>      <b>Zip Code:</b>  <input type="text"/> <input type="text"/> - <input type="text"/></p> <p><b>Phone:</b>                  (<input type="text"/><input type="text"/><input type="text"/>) <input type="text"/> - <input type="text"/></p>
<p><b>Check the Medicare Supplement Plan You Prefer:</b></p> <p><input type="checkbox"/> <b>Standardized Plan A</b>    <input type="checkbox"/> <b>Standardized Plan F</b></p> <p><input type="checkbox"/> <b>Standardized Plan D</b>    <input type="checkbox"/> <b>Standardized Plan G</b></p>	

Age	Date Of Birth	Gender	Height Weight	Social Security Number
<input type="text"/>	<i>Month Day Year</i> <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> <i>Male</i> <input type="checkbox"/> <i>Female</i>	<input type="text"/> <i>ft</i> <input type="text"/> <i>in</i> <input type="text"/> <i>lbs</i>	<input type="text"/> - <input type="text"/> - <input type="text"/>

MEDICARE INFORMATION

Medicare Claim Number:

*Premium Payment*

**Modal Premium:**                      \$ ,

**Total Submitted Premium:**      \$ ,      **Requested Effective Date:** --

or     **Draft Initial Monthly Premium**

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

Annual       Semiannual       Quarterly       Monthly Bank Draft

I authorize Bank Draft payments.      Account Type:     Checking     Savings

**Bank Routing # (9 digits):**    **Bank Account # (do not include check #):**                      **Select Bank Draft Day:**  
                                           

Bank Name: \_\_\_\_\_

Name(s) of Depositor(s): \_\_\_\_\_

Please include a voided check.

**PART I - MEDICARE & INSURANCE INFORMATION (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. Did you turn age 65 in the last six months?  Yes  No
- 2. Did you enroll in Medicare Part B in the last six months?  Yes  No

If "Yes", what is the effective date? --

- 3. 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

- 4. 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. (If you are still covered under the other policy, leave "END" blank.)

Start -- End --

- b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?  Yes  No
- c. Was this your first time in this type of Medicare plan?  Yes  No
- d. Did you drop a Medicare Supplement plan to enroll in the Medicare plan?  Yes  No

- 5. 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

- 6. 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 and what kind of policy?

b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

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 1-8 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 benefits; or 2) is primary to Medicare and the plan terminates or the plan ceases to provide all 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 circumstance 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, 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, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then the insured person terminates coverage within 12 months or enrollment; or

- f. Upon first becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage or PACE provider and then disenrolled within 12 months
- g. Terminated coverage under a Medicare Supplement policy that covers outpatient prescription drugs and enrolled in a Medicare Part D plan during the initial enrollment period.

**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

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 premiums have 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.

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

**Fraud 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:   -   -      
(Month/Day/Year)

Applicant's Signature: \_\_\_\_\_

Writing Agent's Signature: \_\_\_\_\_

Agent Number:

Mail policy to  Agent  Applicant

**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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 #1 Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent #2 Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent #1 Name (please print)	Agent #	Split %
<input type="text"/>	<input type="text"/>	<input type="text"/>

Agent #2 Name (please print)	Agent #	Split %
<input type="text"/>	<input type="text"/>	<input type="text"/>

*You have selected Plan F, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

- 61st to 90th Day Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.
- Lifetime Reserve Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.
- Following the Lifetime Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

- Part A & B Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

- Part B Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

## **ADDITIONAL BENEFITS**

- Medicare Part A Deductible** When You are confined as an inpatient to a Hospital, We will pay You the Medicare Part A Inpatient Hospital Deductible in any Medicare Benefit Period.
- Skilled Nursing Facility Benefit** We will pay You the actual billed charges up to the daily coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital skilled nursing facility care eligible under Medicare, Part A.
- Medicare Part B Deductible** We will pay You for all Eligible Expenses used to satisfy Your Medicare Part B deductible amount per calendar year regardless of Hospital Confinement.
- 100% of the Medicare Part B Excess Charges** We will pay You 100% of the difference between the actual Medicare Part B billed charge, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.
- Medically Necessary Emergency Care in a Foreign Country** When You are traveling outside the United States and require Emergency Care, we will pay You 80% of the billed charges after a calendar year deductible of \$250. Emergency Care shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset beginning during the first 60 consecutive days of each trip outside the United States. Medical services must be of the type that Medicare would have covered if the care had been received in the United States. This benefit is subject to a lifetime maximum of \$50,000 dollars.

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
 Company Tracking Number: 90000 AR  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement  
 Project Name/Number: 90000/90000

## 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.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Medicare Supplement Policy Plan F 02/12/2009		90000-g_ar.pdf
No original date	Form	Application - Medicare Supplement Insurance 02/12/2009		A-HNL 08 AR.pdf
No original date	Form	Medicare Supplement Policy Plan a 01/19/2009		90000-a_ar.pdf
No original date	Form	Medicare Supplement Policy Plan D01/19/2009		90000-d_ar.pdf
No original date	Form	Medicare Supplement Policy Plan F 01/19/2009		90000-f_ar.pdf
No original date	Form	Medicare Supplement Policy Plan G 01/19/2009		90000-g_ar.pdf
No original date	Form	Application - Medicare Supplement Insurance 01/19/2009		app-90020_ar.pdf
No original date	Form	Outline of Coverage	01/19/2009	Olc90000-2009_ar.pdf
No original date	Rate and Rule	Actuarial Memorandum	01/19/2009	Medicare Supplement Actuarial Memorandum_AR_2_.pdf

SERFF Tracking Number: ETPF-125992439 State: Arkansas  
Filing Company: Heartland National Life Insurance Company State Tracking Number: 41383  
Company Tracking Number: 90000 AR  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement  
Project Name/Number: 90000/90000

No original date	Rate and Rule	Rate Schedule	01/19/2009	Heartland_MedS upp_RateSheets AR.pdf
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**YOU HAVE SELECTED PLAN G. THIS POLICY PROVIDES BENEFITS WHICH SUPPLEMENT MEDICARE. IT IS GUARANTEED RENEWABLE FOR YOUR LIFETIME. WE HAVE THE RIGHT TO CHANGE PREMIUMS ONLY ON A CLASS BASIS BY STATE.**

**Medicare Supplement Policy** We Insure You, named as the Insured on the Policy Schedule. We promise to pay the benefits provided in this Policy for covered losses that are incurred while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached. **Notice to Buyer: This Policy may not cover all of Your medical expenses.**

**Your Thirty Day Right to Examine This Policy** If for any reason You are not satisfied with this Policy, You may return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all premiums You paid to Us and then You and We will be in the same position as if a Policy had never been issued.

**Coverage for Pre-existing Conditions** Benefits will be paid for all covered losses under this Policy, even those caused by a Sickness, Injury or physical condition that existed before the Effective Date of the Policy. Loss occurring during a Confinement is considered to commence with the first day of such Confinement.

**Renewal Conditions** You may renew this Policy as long as You live. To renew, just pay a renewal premium. It must be paid on or before the end of the premium period, within the Grace Period, or during the Conservation Period. After this Policy is in force We cannot refuse to renew it or place any restrictions on it if the premium is paid on time.

**Premium Changes** We will not change the premiums for this Policy during Your first year of coverage within the 90000 Series. Thereafter, we can change them, but only if We change them for all policies like Yours in Your state on a class basis. A class is determined by benefits selected and year of issue. No rate adjustment may be made on an individual basis. Notice will be given to You at least 31 days before any premium change.

Your Policy benefits automatically change in accordance with Policy provisions whenever Medicare benefits change. After Your first year of coverage, the renewal premium for this Policy may change on a renewal date following the Effective Date of any change in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. Any such premium change will be based on the actuarial computations that We then use to determine the renewal premium.

**Consideration & Effective Date** This Policy is issued in consideration of the statements in Your application for insurance that is attached to and is made a part of this Policy, and the payment of the initial premium. This payment will keep the Policy in force until the first renewal date. The initial premium and the first renewal date are shown on Page 2. Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown on Page 2. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.

  
Secretary

  
President

**POLICY SCHEDULE**

Plan: Policy Number:  
Insured: Effective Date:  
First Renewal Date:  
Initial Premium:  
Endorsements:

**Renewal Premiums**

Annual                      Semi-Annual                      Quarterly                      Monthly Bank Draft

*You have selected Plan G, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

- 61st to 90th Day Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.
- Lifetime Reserve Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.
- Following the Lifetime Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

- Part A & B Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

- Part B Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

## **ADDITIONAL BENEFITS**

- Medicare Part A Deductible** When You are confined as an inpatient to a Hospital, We will pay You the Medicare Part A Inpatient Hospital Deductible in any Medicare Benefit Period.
- Skilled Nursing Facility Benefit** We will pay You the actual billed charges up to the daily Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital skilled nursing facility care eligible under Medicare Part A.
- 80% of the Medicare Part B Excess Charges** We will pay You 80% of the difference between the actual Medicare Part B billed charge, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.
- Medically Necessary Emergency Care in a Foreign Country** When You are traveling outside the United States and require Emergency Care, we will pay You 80% of the billed charges after a calendar year deductible of \$250. Emergency Care shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset beginning during the first 60 consecutive days of each trip outside the United States. Medical services must be of the type that Medicare would have covered if the care had been received in the United States. This benefit is subject to a lifetime maximum of \$50,000 dollars.

**Benefits are continued on Page 4**

### ADDITIONAL BENEFITS (continued)

#### **At-Home Recovery Benefit**

We will pay You the actual charge, up to \$40 dollars per visit, for short term assistance with Activities of Daily Living furnished in Your Home by a Care Provider when you are recovering from a Sickness, Injury or surgery. You may receive up to 7 visits per week, with a calendar year maximum of 40 visits or \$1,600 dollars.

To receive benefits, Your Doctor must certify that the type and frequency of At-Home Recovery Visits are necessary because of a condition for which Your home care plan of treatment was approved by Medicare. All visits must be received during the period in which You are receiving Medicare approved home health care services, or within 8 weeks of the last date of service of a Medicare approved home health visit. In no event shall the total number of At-Home Recovery Visits exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

For purposes of this benefit, the following definitions shall apply:

(i) "Activities of Daily Living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings. (ii) "Care Provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry. (iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A Hospital or skilled nursing facility shall not be considered the insured's place of residence. (iv) "At-Home Recovery Visit" means the period of a visit required to provide At-Home Recovery Care, without limit on the duration of the visit, except each consecutive 4 hours in a 24 hour period of services provided by a Care Provider is one visit.

Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and (ii) care provided by family members, unpaid volunteers or providers who are not Care Providers.

## DEFINITIONS

*The person named as the "Insured" on Page 2 of this Policy is referred to in this Policy as You, Your, Yours, or Insured and Heartland National Life Insurance Company as We, Our or Us.*

<b>Benefit Period</b>	Means a period that begins, after the Effective Date of this Policy, with the first day of Hospital Confinement and ends at the close of 60 consecutive days during which You were not confined to a Hospital or skilled nursing facility.
<b>Coinsurance</b>	Means the difference between the Medicare approved amount and the Medicare payment after You have satisfied the applicable Medicare deductibles.
<b>Confinement</b>	Means medically required stay as a resident inpatient in a Hospital or skilled nursing facility. It must be on the specific recommendation and under the general supervision of a Doctor.
<b>Doctor</b>	Means a duly licensed person practicing in the healing arts and acting within the scope of that license in treating a Sickness or Injury. A Doctor must be other than an immediate member of Your family.
<b>Hospital</b>	Means a place that is licensed as a Hospital pursuant to law and is legally operated for the care and treatment of sick or injured persons at their expense. A Hospital does not include the following kinds of facilities (including units in a Hospital used for such care); (a) convalescent, nursing home, rest home, or nursing care facilities; (b) places that primarily treat the aged, drug addicts or alcoholics; and (c) facilities that primarily provide custodial or educational care.
<b>Injury</b>	Means bodily harm sustained by You which: (a) is the direct result of an accident or trauma that occurs while Your Policy is in force; and (b) is not related to Sickness, bodily infirmity or any other cause.
<b>Inpatient Hospital Deductible</b>	Means the initial Hospital expense incurred during a Benefit Period for which You are responsible under Medicare.
<b>Medicare</b>	Means Title XVIII of the United States Social Security Act of 1965, as then constituted or later amended.
<b>Medicare Part A</b>	Means the program under Medicare officially called "Hospital Insurance Benefit for the Aged and Disabled".
<b>Medicare Part B</b>	Means the program under Medicare officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled".
<b>Medicare Eligible Expenses</b>	Means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
<b>Sickness</b>	Means illness or disease of an insured person.

## LIMITATIONS & EXCLUSIONS

<b>Limitations &amp; Exclusions</b>	We will not pay benefits under this Policy for: <ul style="list-style-type: none"><li>a) Any expense which is not eligible for payment under Medicare, unless otherwise covered in Your Policy or by optional endorsement; or</li><li>b) Any expense which You are not legally obligated to pay.</li></ul>
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## ELIGIBILITY FOR COVERAGE

<b>Individual Not Covered by Medicare</b>	If You have not established entitlement to benefits under Medicare, We will provide benefits under this Policy as though You had established entitlement.
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## POLICY SUSPENSION

<b>Medicaid Entitlement</b>	<p>If You apply for and become entitled to medical assistance under Medicaid, the benefits and premiums under Your Policy will be suspended, if requested, for up to 24 months during Your Medicaid Entitlement. You must request this suspension within 90 days of becoming entitled to Medicaid.</p> <p>If You lose Your entitlement to Medicaid while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Medicaid Entitlement and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Medicaid Entitlement is terminated.</p>
<b>Group Health Plan Coverage</b>	<p>If You were eligible for, and purchased this Policy by reason of disability and You become covered under an employer or union based group health plan, Your benefits and premiums under this Policy will be suspended, if requested, while You are covered under the group health plan.</p> <p>If You lose coverage under Your group health plan while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Group Health Plan Coverage and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Group Health Plan Coverage is terminated.</p>
<b>Reinstitution</b>	<p>Your reinstated Policy will provide the same or substantially equivalent coverage that was in effect when your Policy was suspended. The premium for Your reinstated Policy will be on the same terms that would have applied had Your Policy not been suspended.</p>

## GENERAL PROVISIONS

<b>Entire Contract; Changes</b>	<p>This Policy with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.</p>
<b>Conformity with State Laws</b>	<p>Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that Effective Date is amended to conform to the minimum requirements of such laws.</p>
<b>Notice of Claim</b>	<p>Written Notice of Claim must be given within 6 months after a covered loss begins or as soon as possible. The notice can be given to Us at the address shown on Page 8, or to any one of Our agents. The notice should include Your name and Policy number.</p>
<b>Claim Forms</b>	<p>When We receive Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not sent to You within 15 days after giving such notice, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.</p>
<b>Electronic Claim Filing Process</b>	<p>Your health care providers will usually submit electronically to Medicare the billed charges for any medical or Hospital expenses You incur. Medicare then processes the benefits for expenses eligible under Part A and/or B, and then passes Your claim electronically to Us for consideration of benefits under Your Policy. We will accept Medicare's electronic submission of Your claim to Us as Your Notice of Claim and Your Claim Form. For consideration of expenses that are not submitted electronically to Us, a paper copy of Your Medicare Summary Notice can serve as Your Notice of Claim and Claim Form. The Medicare Summary Notice shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare Summary Notice to Us or Your health care provider may submit it to Us on Your behalf.</p>
<b>Proofs of Loss</b>	<p>Written Proof of Loss must be given to Us within 90 days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.</p>

<b>Payment of Benefits</b>	All benefits will be paid to You, or Your assignee. Benefits unpaid at Your death may be paid to Your estate or We may pay up to \$1,000 to any relative of Yours who is entitled to them. Any payment made in good faith will fully release Us to the extent of that payment.
<b>Timely Payment of Benefits</b>	Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.
<b>Assignment</b>	No assignment of benefits under this Policy shall be binding upon Us unless the original (or copy of it) is on file with Us. We do not assume any responsibility for the validity of any assignment.
<b>Other Insurance With Us</b>	Your insurance under a like policy or policies with Us is limited to one such policy elected by You, Your beneficiary or Your estate, as the case may be, and We will return all premiums paid for all such other policies.
<b>Grace Period</b>	This Policy has a 31 day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period this Policy will stay in force.
<b>Conservation Period</b>	We offer You an additional 15 days beyond the Grace Period to pay Your premium. During this 15 day extension, this Policy is not in force unless Your premium is paid within this period. The Policy will then be renewed with no lapse in coverage.
<b>Unpaid Premium</b>	We reserve the right to deduct any premium due and unpaid from a claim payment.
<b>Reinstatement</b>	<p>If the renewal premium is not paid before the Grace Period ends or within the Conservation Period, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for Reinstatement will Reinstatement this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be Reinstated as of the approval date. Lacking such approval this Policy will be Reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.</p> <p>The Reinstated Policy will only cover losses that result from Injury or Sickness sustained after the date of Reinstatement. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any premium accepted with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.</p>
<b>Continuation of Coverage</b>	We cannot terminate Your Policy as long as You pay Your premium on time. Termination of coverage under this Policy shall be without prejudice to any continuous loss for Confinement to a Hospital or skilled nursing facility that commences while this Policy is in force and during which You are determined to be continuously totally disabled. In this Policy, "continuously totally disabled" means the complete inability of a person to engage in all the normal activities of a person of the same age and gender.
<b>Refund of Unearned Premium</b>	We will refund that part of any premium paid which covers a period beyond the end of the Policy month of Your death.
<b>Time Limit on Certain Defenses</b>	No statements, except fraudulent misstatements, made by You in the application for this Policy, shall be used to void this Policy or to deny a claim for loss incurred after 2 years from the Effective Date of this Policy. No claim for loss occurring after the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition had existed before the Effective Date of this Policy.
<b>Legal Action</b>	No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years after the time written Proof of Loss is required to be given.

## YOUR MEDICARE SUPPLEMENT POLICY

If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.

If You have any questions about Your Policy, please write to Us and We will be happy to help You, or call Us, on Our toll free number listed above.

**Heartland National Life Insurance Company**  
**PO Box 2878**  
**Salt Lake City, Utah 84110-2878**

<p>Policy Benefits</p> <p style="padding-left: 20px;">Basic Benefits ..... Page 3</p> <p style="padding-left: 40px;">61st to 90th day</p> <p style="padding-left: 40px;">Lifetime Reserve</p> <p style="padding-left: 40px;">Following Lifetime Reserve</p> <p style="padding-left: 40px;">Part A &amp; B Blood</p> <p style="padding-left: 40px;">Part B Coinsurance</p> <p style="padding-left: 20px;">Additional Benefits (if any) ..... Page 3 &amp; 4</p> <p>Consideration ..... Page 1</p> <p>Coverage for Pre-existing Conditions ..... Page 1</p> <p>Definitions ..... Page 5</p> <p style="padding-left: 20px;">Benefit Period</p> <p style="padding-left: 20px;">Coinsurance</p> <p style="padding-left: 20px;">Confinement</p> <p style="padding-left: 20px;">Doctor</p> <p style="padding-left: 20px;">Hospital</p> <p style="padding-left: 20px;">Injury</p> <p style="padding-left: 20px;">Inpatient Hospital Deductible</p> <p style="padding-left: 20px;">Medicare</p> <p style="padding-left: 20px;">Medicare Part A</p> <p style="padding-left: 20px;">Medicare Part B</p> <p style="padding-left: 20px;">Medicare Eligible Expenses</p> <p style="padding-left: 20px;">Sickness</p> <p>Effective Date ..... Pages 1 &amp; 2</p>	<p>General Provisions ..... Pages 6 &amp; 7</p> <p style="padding-left: 20px;">Assignment</p> <p style="padding-left: 20px;">Claim Forms</p> <p style="padding-left: 20px;">Conformity with State Laws</p> <p style="padding-left: 20px;">Conservation Period</p> <p style="padding-left: 20px;">Continuation of Coverage</p> <p style="padding-left: 20px;">Electronic Claim Filing Process</p> <p style="padding-left: 20px;">Entire Contract; Changes</p> <p style="padding-left: 20px;">Grace Period</p> <p style="padding-left: 20px;">Legal Action</p> <p style="padding-left: 20px;">Misstatement of Age</p> <p style="padding-left: 20px;">Notice of Claim</p> <p style="padding-left: 20px;">Other Insurance with Us</p> <p style="padding-left: 20px;">Payment of Benefits</p> <p style="padding-left: 20px;">Proofs of Loss</p> <p style="padding-left: 20px;">Refund of Unearned Premium</p> <p style="padding-left: 20px;">Reinstatement</p> <p style="padding-left: 20px;">Time Limit on Certain Defenses</p> <p style="padding-left: 20px;">Timely Payment of Benefits</p> <p style="padding-left: 20px;">Unpaid Premium</p> <p>Individual Not Covered By Medicare ..... Page 5</p> <p>Limitations And Exclusions ..... Page 5</p> <p>Policy Suspension ..... Page 6</p> <p>Premium Changes ..... Page 1</p> <p>Renewal Conditions ..... Page 1</p> <p>Your Thirty Day Right to Examine This Policy ..... Page 1</p>
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HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: Indiana

Medicare Supplement Administrative Office: PO Box 2878, Salt Lake City, UT 84110-2878

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

<p><b>Applicant Last</b>  <input type="text"/></p> <p><b>First</b> <span style="float:right"><b>MI</b></span>  <input type="text"/> <input type="text"/></p>	<p><b>Residence Address: Street:</b>  <input type="text"/></p> <p><b>City:</b>  <input type="text"/></p> <p><b>State:</b>      <b>Zip Code:</b>  <input type="text"/> <input type="text"/> - <input type="text"/></p> <p><b>Phone:</b>                  ( <input type="text"/> <input type="text"/> ) <input type="text"/> - <input type="text"/></p>
<p><b>Check the Medicare Supplement Plan You Prefer:</b></p> <p><input type="checkbox"/> <b>Standardized Plan A</b>    <input type="checkbox"/> <b>Standardized Plan F</b></p> <p><input type="checkbox"/> <b>Standardized Plan D</b>    <input type="checkbox"/> <b>Standardized Plan G</b></p>	

Age	Date Of Birth	Gender	Height Weight	Social Security Number
<input type="text"/>	<i>Month Day Year</i> <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> <i>Male</i> <input type="checkbox"/> <i>Female</i>	<input type="text"/> <i>ft</i> <input type="text"/> <i>in</i> <input type="text"/> <i>lbs</i>	<input type="text"/> - <input type="text"/> - <input type="text"/>

MEDICARE INFORMATION

Medicare Claim Number:

Premium Payment

**Modal Premium:**                      \$ ,

**Total Submitted Premium:**      \$ ,       **Requested Effective Date:**  -  -

or     **Draft Initial Monthly Premium**

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

Annual       Semiannual       Quarterly       Monthly Bank Draft

I authorize Bank Draft payments.

**Bank Routing # (9 digits):**  | **Bank Account # (do not include check #):**       **Select Bank Draft Day:**

Bank Name: \_\_\_\_\_

Name(s) of Depositor(s): \_\_\_\_\_

Please include a voided check. The first draft will occur on the premium-due date after the policy has been issued. Subsequent drafts will occur on or shortly following the selected draft day requested above (never before).

**PART I - MEDICARE & INSURANCE INFORMATION (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. Did you turn age 65 in the last six months?  Yes  No
- 2. Did you enroll in Medicare Part B in the last six months?  Yes  No

If "Yes", what is the effective date? --

- 3. 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

- 4. 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. (If you are still covered under the other policy, leave "END" blank.)

Start -- End --

- b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?  Yes  No
- c. Was this your first time in this type of Medicare plan?  Yes  No
- d. Did you drop a Medicare Supplement plan to enroll in the Medicare plan?  Yes  No

- 5. 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

- 6. 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 and what kind of policy?

b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

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 1-8 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 benefits; or 2) is primary to Medicare and the plan terminates or the plan ceases to provide all 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 circumstance 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, 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, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then the insured person terminates coverage within 12 months or enrollment; or

- f. Upon first becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage or PACE provider and then disenrolled within 12 months
- g. Terminated coverage under a Medicare Supplement policy that covers outpatient prescription drugs and enrolled in a Medicare Part D plan during the initial enrollment period.

**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

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 premiums 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.

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

**Fraud 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: --  
(Month/Day/Year)

Applicant's Signature: \_\_\_\_\_

Writing Agent's Signature: \_\_\_\_\_

Agent Number:

Mail policy to  Agent  Applicant

**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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 #1 Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent #2 Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent #1 Name (please print) \_\_\_\_\_ Agent # \_\_\_\_\_ Split % \_\_\_\_\_  
[Grid of boxes for name, agent number, and split percentage]

Agent #2 Name (please print) \_\_\_\_\_ Agent # \_\_\_\_\_ Split % \_\_\_\_\_  
[Grid of boxes for name, agent number, and split percentage]

## HEALTH QUESTIONS

**Do not answer health questions 1-9 if you are in open enrollment or a guaranteed issued period. Please see page three for an explanation of open enrollment/guaranteed issue period information.**

**If You Answer “YES” to any part of questions 1-6 you are not eligible for coverage.**

**NOTICE TO APPLICANT: Please verify the accuracy and completeness of the medical information on this application. In complete or false information on this application could jeopardize future claims.**

- 1.) Have you been hospitalized, confined to a nursing facility or received home health care within the past 60 days or been hospitalized 3 or more times in the past 2 years?  Yes  No
- 2.) 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
- 3.) In the past two years, have you been advised by a physician or other member of the medical profession to have surgery, medical tests, or an organ transplant that has not been performed?  Yes  No
- 4.) Have you been advised by a physician or other member of the medical profession that you need to have surgery performed within the next twelve months?  Yes  No
- 5.) Do you have now, or during the past five years have you received medical treatment, or been medically advised to have treatment, surgery or taken medication for any of the following conditions:
  - a. Parkinson’s Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Alzheimer’s Disease or dementia?  Yes  No
  - b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV)?  Yes  No
  - c. Insulin Dependent Diabetes, uncontrolled diabetes or diabetes with complications such as retinopathy, neuropathy or kidney problems?  Yes  No
  - d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any chronic pulmonary condition requiring the use of oxygen?  Yes  No
  - e. Internal Cancer, Leukemia, malignant melanoma, Hodgkins Disease or Lymphoma?  Yes  No
  - f. Osteoporosis with related fractures?  Yes  No
  - g. Any kidney disease requiring dialysis?  Yes  No
- 6.) Within the past 2 years have you had, been medically treated for, or has treatment been recommended by a physician or other member of the medical profession for:
  - a. Heart surgery, congestive heart failure, heart attack, peripheral vascular disease, arrhythmia, stroke, or transient ischemic attack (TIA)?  Yes  No
  - b. Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse?  Yes  No
  - c. Amputation caused by disease?  Yes  No
  - d. Mental or nervous disorder requiring psychiatric care?  Yes  No
  - e. Disabling, crippling or rheumatoid arthritis?  Yes  No
- 7.) Do you require the use of a wheelchair?  Yes  No

**Additional Questions:**

- 8.) Have you used tobacco in any form in the last 2 years?  Yes  No
- 9.) Are you taking or have you taken any prescription drugs or over the counter medications within the past 12 months?  
If, Yes, please list the drug and the reason prescribed below.  Yes  No

Prescription Name	Reason Prescribed

**DOCTOR YOU USUALLY CONSULT - Your Primary Care Physician**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

# Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided services, treatment or payment to me, or on my behalf, within the past 10 years ("My Providers"), or consumer reporting agency, or the Medical Information Bureau, to disclose my entire medical record and any other protected health information concerning me to Heartland National Life Insurance Company ("Heartland") and its agents, employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

**My protected health information is to be disclosed under this Authorization so that Heartland may:** 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill their responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Heartland.

For a period of 120 days from the date of this Authorization I authorize my Heartland Agent to receive certain protected health information about me that is related to an adverse underwriting decision or counteroffer for alternative coverage made during the underwriting of my application.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to: **Heartland National Life Insurance Company at PO Box 2878, Salt Lake City, Utah 84110-2878, Attention: Privacy Officer.** I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Heartland has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Heartland may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

\_\_\_\_\_  
Name of Applicant (please print)

\_\_\_\_\_  
Signature of Applicant or Personal Representative

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority or Relationship to Applicant (if applicable)

HHA (04)

(Return to Company)

\*2020000901\*

**NOTICE TO APPLICANTS REGARDING REPLACEMENT  
OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE**

HEARTLAND NATIONAL LIFE INSURANCE COMPANY  
PO BOX 2878, Salt Lake City, UT 84110-2878

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!**

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage coverage and replace it with a policy to be issued by Heartland National Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your policy or Medicare Advantage coverage only if after due consideration and acceptance by the replacing insurer, you find that purchase of this Medicare Supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

**STATEMENT TO APPLICANT BY AGENT:** I have reviewed your current medical or health insurance coverage. To the best of my knowledge this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.  Same benefits, but lower premium.  
 Fewer benefits and lower premiums.  
 My plan has outpatient prescription drug coverage and I am enrolling in Part D.  
 Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

Other (please specify).  
\_\_\_\_\_

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

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

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Producers PRINTED name and address

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

*Producer: If this replacement notice is necessary, have the insured complete and sign this form and leave it with the Applicant.*

**NOTICE TO APPLICANTS REGARDING REPLACEMENT  
OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE**

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

PO BOX 2878, Salt Lake City, UT 84110-2878

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- Additional benefits.  Same benefits, but lower premium.
- Fewer benefits and lower premiums.
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- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

Other (please specify). \_\_\_\_\_

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

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

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Producers PRINTED name and address

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

*Producer: If this replacement notice is necessary, have the insured complete and sign this form and return it to us with all other forms.*

HRN-07

Return to Company

\*90000002001\*

## NOTICE OF OUR INFORMATION PRACTICES AND PRIVACY POLICY

With your application for insurance we receive personal information about you. You also authorized us to collect your health information. We keep and protect all such information as confidential and do not disclose it to any other persons, entities or organizations unless authorized by you in writing or as allowed or required by law. "We" or "Our" is defined as Heartland National Life Insurance Company and its Third Party Administrator (TPA), Equitable Life & Casualty Insurance Company.

### **Information We Collect And Receive**

Personal information we receive about you comes directly from you, such as your name, address, birth date, Social Security number, telephone number, or e-mail address. Health (medical) information about you comes from you and your health care providers (doctors, clinics, hospitals, laboratories, etc.) based on your written Authorization. We may also review information about you on file with the MIB Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members.

### **What We Do With This Information**

Your personal information is entered in our system to identify you as our customer. Other uses of your personal and health information include underwriting your application for insurance and assisting you in a claim for benefits. Your Heartland agent, as our business associate, may have access to your health information during the underwriting process, as authorized by you, and access to your personal information for assistance with your insurance needs.

Under our established procedures, if upon the consideration of your medical information we determine you do not meet our underwriting guidelines for the issuance of a policy, the medical reason(s) for a declination of coverage may be disclosed to the person or entity (usually your doctor) who maintains your medical information. Your doctor can then discuss with you, through a private consultation, the medical reason(s) for our decision.

### **How We Protect This Information**

Our employees and agents are required to keep your personal and health information confidential. Our intention is to request or access only the minimum amount of information necessary. We maintain all your personal or health information in a secured database, with security and procedural measures in place, in compliance with federal law, to safeguard your protected information and alert us if and when unauthorized access is attempted.

We do not disclose your personal or health information with any nonaffiliated third party (person, entity or organization) without your written permission, unless allowed or required by law. Under no circumstances will any information be disclosed to any nonaffiliated party for marketing purposes, such as telemarketing, direct mail or electronic mail marketing.

### **How You Can Access This Information**

Write to us and request copies of the personal information we have about you in our records. You can also find out who we have disclosed this information to and for what reason. If you believe any personal or health information we have about you is incomplete, inaccurate or incorrect, you have the right to request that we correct or delete it. If your request concerns health information we received from a doctor, hospital or other medical provider, we will refer you to that person or entity. You may, in a private consultation with them, have the necessary corrections made to your health information and sent to us.

### **The MIB Inc.**

Information regarding your insurability will be treated as confidential. Heartland National Life Insurance Company, its TPA, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB, toll free, at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Heartland National Life Insurance Company, its TPA, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

If you have any questions about this Notice, we can be contacted at:

**Heartland National Life Insurance Company**  
**PO Box 2878, Salt Lake City, UT 84110-2878**  
**ATTN: Privacy Officer**  
Telephone (toll free): 1-866-916-7971

**Leave with Applicant**

Receipt

**Receipt**

*Please Note: All premium checks must be made payable to Heartland National Life Insurance Company.  
Do not make checks payable to the insurance agent or leave the payee line blank.*

Received from \_\_\_\_\_ the sum  
of \$ \_\_\_\_\_ for \_\_\_\_\_ months premium, with this application. If for any rea-  
son the application is not approved and the policy is not issued, this premium is to be refunded. No li-  
ability is created or assumed by the Company, except for refund of this premium, until the policy applied  
for has been issued.

Date Receipt and Outline of Coverage was prepared \_\_\_\_\_, 20 \_\_\_\_\_

by \_\_\_\_\_  
*Agent's Signature*

Heartland National Life Insurance Company, PO Box 2878, Salt Lake City, UT 84110-2878

**YOU HAVE SELECTED PLAN A. THIS POLICY PROVIDES BENEFITS WHICH SUPPLEMENT MEDICARE. IT IS GUARANTEED RENEWABLE FOR YOUR LIFETIME. WE HAVE THE RIGHT TO CHANGE PREMIUMS ONLY ON A CLASS BASIS BY STATE.**

**Medicare Supplement Policy** We Insure You, named as the Insured on the Policy Schedule. We promise to pay the benefits provided in this Policy for covered losses that are incurred while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached. **Notice to Buyer: This Policy may not cover all of Your medical expenses.**

**Your Thirty Day Right to Examine This Policy** If for any reason You are not satisfied with this Policy, You may return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all premiums You paid to Us and then You and We will be in the same position as if a Policy had never been issued.

**Coverage for Pre-existing Conditions** Benefits will be paid for all covered losses under this Policy, even those caused by a Sickness, Injury or physical condition that existed before the Effective Date of the Policy. Loss occurring during a Confinement is considered to commence with the first day of such Confinement.

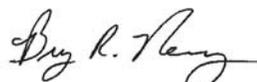
**Renewal Conditions** You may renew this Policy as long as You live. To renew, just pay a renewal premium. It must be paid on or before the end of the premium period, within the Grace Period, or during the Conservation Period. After this Policy is in force We cannot refuse to renew it or place any restrictions on it if the premium is paid on time.

**Premium Changes** We will not change the premiums for this Policy during Your first year of coverage within the 90000 Series. Thereafter, we can change them, but only if We change them for all policies like Yours in Your state on a class basis. A class is determined by benefits selected, year of issue and/or your age at entry. No rate adjustment may be made on an individual basis. Notice will be given to You at least 31 days before any premium change.

Your Policy benefits automatically change in accordance with Policy provisions whenever Medicare benefits change. After Your first year of coverage, the renewal premium for this Policy may change on a renewal date following the Effective Date of any change in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. Any such premium change will be based on the actuarial computations that We then use to determine the renewal premium.

**Consideration & Effective Date** This Policy is issued in consideration of the statements in Your application for insurance that is attached to and is made a part of this Policy, and the payment of the initial premium. This payment will keep the Policy in force until the first renewal date. The initial premium and the first renewal date are shown on Page 2. Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown on Page 2. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.

  
Secretary

  
President

**POLICY SCHEDULE**

Plan:

Policy Number:

Insured:

Effective Date:

First Renewal Date:

Initial Premium:

Endorsements:

Premium: See scale of attained age premiums on outline of coverage

**Renewal Premiums**

Annual

Semi-Annual

Quarterly

Monthly Bank Draft

*You have selected Plan A, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

**61st to 90th Day  
Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.

**Lifetime  
Reserve  
Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.

**Following the  
Lifetime  
Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

**Part A & B  
Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

**Part B  
Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

*(This Page has been left blank intentionally.)*

## DEFINITIONS

*The person named as the "Insured" on Page 2 of this Policy is referred to in this Policy as You, Your, Yours, or Insured and Heartland National Life Insurance Company as We, Our or Us.*

<b>Benefit Period</b>	Means a period that begins, after the Effective Date of this Policy, with the first day of Hospital Confinement and ends at the close of 60 consecutive days during which You were not confined to a Hospital or skilled nursing facility.
<b>Coinsurance</b>	Means the difference between the Medicare approved amount and the Medicare payment after You have satisfied the applicable Medicare deductibles.
<b>Confinement</b>	Means medically required stay as a resident inpatient in a Hospital or skilled nursing facility. It must be on the specific recommendation and under the general supervision of a Doctor.
<b>Doctor</b>	Means a duly licensed person practicing in the healing arts and acting within the scope of that license in treating a Sickness or Injury. A Doctor must be other than an immediate member of Your family.
<b>Hospital</b>	Means a place that is licensed as a Hospital pursuant to law and is legally operated for the care and treatment of sick or injured persons at their expense. A Hospital does not include the following kinds of facilities (including units in a Hospital used for such care); (a) convalescent, nursing home, rest home, or nursing care facilities; (b) places that primarily treat the aged, drug addicts or alcoholics; and (c) facilities that primarily provide custodial or educational care.
<b>Injury</b>	Means bodily harm sustained by You which: (a) is the direct result of an accident or trauma that occurs while Your Policy is in force; and (b) is not related to Sickness, bodily infirmity or any other cause.
<b>Inpatient Hospital Deductible</b>	Means the initial Hospital expense incurred during a Benefit Period for which You are responsible under Medicare.
<b>Medicare</b>	Means Title XVIII of the United States Social Security Act of 1965, as then constituted or later amended.
<b>Medicare Part A</b>	Means the program under Medicare officially called "Hospital Insurance Benefit for the Aged and Disabled".
<b>Medicare Part B</b>	Means the program under Medicare officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled".
<b>Medicare Eligible Expenses</b>	Means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
<b>Sickness</b>	Means illness or disease of an insured person.

## LIMITATIONS & EXCLUSIONS

<b>Limitations &amp; Exclusions</b>	We will not pay benefits under this Policy for: <ul style="list-style-type: none"><li>a) Any expense which is not eligible for payment under Medicare, unless otherwise covered in Your Policy or by optional endorsement; or</li><li>b) Any expense which You are not legally obligated to pay.</li></ul>
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## ELIGIBILITY FOR COVERAGE

<b>Individual Not Covered by Medicare</b>	If You have not established entitlement to benefits under Medicare, We will provide benefits under this Policy as though You had established entitlement.
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## POLICY SUSPENSION

<b>Medicaid Entitlement</b>	<p>If You apply for and become entitled to medical assistance under Medicaid, the benefits and premiums under Your Policy will be suspended, if requested, for up to 24 months during Your Medicaid Entitlement. You must request this suspension within 90 days of becoming entitled to Medicaid.</p> <p>If You lose Your entitlement to Medicaid while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Medicaid Entitlement and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Medicaid Entitlement is terminated.</p>
<b>Group Health Plan Coverage</b>	<p>If You were eligible for, and purchased this Policy by reason of disability and You become covered under an employer or union based group health plan, Your benefits and premiums under this Policy will be suspended, if requested, while You are covered under the group health plan.</p> <p>If You lose coverage under Your group health plan while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Group Health Plan Coverage and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Group Health Plan Coverage is terminated.</p>
<b>Reinstitution</b>	<p>Your reinstated Policy will provide the same or substantially equivalent coverage that was in effect when your Policy was suspended. The premium for Your reinstated Policy will be on the same terms that would have applied had Your Policy not been suspended.</p>

## GENERAL PROVISIONS

<b>Entire Contract; Changes</b>	<p>This Policy with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.</p>
<b>Conformity with State Laws</b>	<p>Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that Effective Date is amended to conform to the minimum requirements of such laws.</p>
<b>Misstatement of Age</b>	<p>If Your age has been misstated, We will pay only such amounts as the premium paid would have purchased at the correct age. In the event an age is overstated, We will refund any premium that may be due when We have been notified of this fact. If according to the correct age the Policy would not have become effective for any reason, Our liability shall be limited to the refund of the premium paid, subject to an adjustment for paid claims.</p>
<b>Notice of Claim</b>	<p>Written Notice of Claim must be given within 6 months after a covered loss begins or as soon as possible. The notice can be given to Us at the address shown on Page 8, or to any one of Our agents. The notice should include Your name and Policy number.</p>
<b>Claim Forms</b>	<p>When We receive Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not sent to You within 15 days after giving such notice, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.</p>
<b>Electronic Claim Filing Process</b>	<p>Your health care providers will usually submit electronically to Medicare the billed charges for any medical or Hospital expenses You incur. Medicare then processes the benefits for expenses eligible under Part A and/or B, and then passes Your claim electronically to Us for consideration of benefits under Your Policy. We will accept Medicare's electronic submission of Your claim to Us as Your Notice of Claim and Your Claim Form. For consideration of expenses that are not submitted electronically to Us, a paper copy of Your Medicare Summary Notice can serve as Your Notice of Claim and Claim Form. The Medicare Summary Notice shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare Summary Notice to Us or Your health care provider may submit it to Us on Your behalf.</p>
<b>Proofs of Loss</b>	<p>Written Proof of Loss must be given to Us within 90 days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.</p>

<b>Payment of Benefits</b>	All benefits will be paid to You, or Your assignee. Benefits unpaid at Your death may be paid to Your estate or We may pay up to \$1,000 to any relative of Yours who is entitled to them. Any payment made in good faith will fully release Us to the extent of that payment.
<b>Timely Payment of Benefits</b>	Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.
<b>Assignment</b>	No assignment of benefits under this Policy shall be binding upon Us unless the original (or copy of it) is on file with Us. We do not assume any responsibility for the validity of any assignment.
<b>Other Insurance With Us</b>	Your insurance under a like policy or policies with Us is limited to one such policy elected by You, Your beneficiary or Your estate, as the case may be, and We will return all premiums paid for all such other policies.
<b>Grace Period</b>	This Policy has a 31 day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period this Policy will stay in force.
<b>Conservation Period</b>	We offer You an additional 15 days beyond the Grace Period to pay Your premium. During this 15 day extension, this Policy is not in force unless Your premium is paid within this period. The Policy will then be renewed with no lapse in coverage.
<b>Unpaid Premium</b>	We reserve the right to deduct any premium due and unpaid from a claim payment.
<b>Reinstatement</b>	<p>If the renewal premium is not paid before the Grace Period ends or within the Conservation Period, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for Reinstatement will Reinstatement this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be Reinstated as of the approval date. Lacking such approval this Policy will be Reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.</p> <p>The Reinstated Policy will only cover losses that result from Injury or Sickness sustained after the date of Reinstatement. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any premium accepted with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.</p>
<b>Continuation of Coverage</b>	We cannot terminate Your Policy as long as You pay Your premium on time. Termination of coverage under this Policy shall be without prejudice to any continuous loss for Confinement to a Hospital or skilled nursing facility that commences while this Policy is in force and during which You are determined to be continuously totally disabled. In this Policy, "continuously totally disabled" means the complete inability of a person to engage in all the normal activities of a person of the same age and gender.
<b>Refund of Unearned Premium</b>	We will refund that part of any premium paid which covers a period beyond the end of the Policy month of Your death.
<b>Time Limit on Certain Defenses</b>	No statements, except fraudulent misstatements, made by You in the application for this Policy, shall be used to void this Policy or to deny a claim for loss incurred after 2 years from the Effective Date of this Policy. No claim for loss occurring after the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition had existed before the Effective Date of this Policy.
<b>Legal Action</b>	No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years after the time written Proof of Loss is required to be given.

**YOUR MEDICARE SUPPLEMENT POLICY**

If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.

If You have any questions about Your Policy, please write to Us and We will be happy to help You, or call Us, on Our toll free number listed above.

**Heartland National Life Insurance Company**  
**PO Box 2878**  
**Salt Lake City, Utah 84110-2878**

<p>Policy Benefits</p> <p>  Basic Benefits ..... Page 3</p> <p>    61st to 90th day</p> <p>    Lifetime Reserve</p> <p>    Following Lifetime Reserve</p> <p>    Part A &amp; B Blood</p> <p>    Part B Coinsurance</p> <p>  Additional Benefits (if any) ..... Page 3 &amp; 4</p> <p>Consideration ..... Page 1</p> <p>Coverage for Pre-existing Conditions ..... Page 1</p> <p>Definitions ..... Page 5</p> <p>  Benefit Period</p> <p>  Coinsurance</p> <p>  Confinement</p> <p>  Doctor</p> <p>  Hospital</p> <p>  Injury</p> <p>  Inpatient Hospital Deductible</p> <p>  Medicare</p> <p>  Medicare Part A</p> <p>  Medicare Part B</p> <p>  Medicare Eligible Expenses</p> <p>  Sickness</p> <p>Effective Date ..... Pages 1 &amp; 2</p>	<p>General Provisions ..... Pages 6 &amp; 7</p> <p>  Assignment</p> <p>  Claim Forms</p> <p>  Conformity with State Laws</p> <p>  Conservation Period</p> <p>  Continuation of Coverage</p> <p>  Electronic Claim Filing Process</p> <p>  Entire Contract; Changes</p> <p>  Grace Period</p> <p>  Legal Action</p> <p>  Misstatement of Age</p> <p>  Notice of Claim</p> <p>  Other Insurance with Us</p> <p>  Payment of Benefits</p> <p>  Proofs of Loss</p> <p>  Refund of Unearned Premium</p> <p>  Reinstatement</p> <p>  Time Limit on Certain Defenses</p> <p>  Timely Payment of Benefits</p> <p>  Unpaid Premium</p> <p>Individual Not Covered By Medicare ..... Page 5</p> <p>Limitations And Exclusions ..... Page 5</p> <p>Policy Suspension ..... Page 6</p> <p>Premium Changes ..... Page 1</p> <p>Renewal Conditions ..... Page 1</p> <p>Your Thirty Day Right to   Examine This Policy ..... Page 1</p>
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**YOU HAVE SELECTED PLAN D. THIS POLICY PROVIDES BENEFITS WHICH SUPPLEMENT MEDICARE. IT IS GUARANTEED RENEWABLE FOR YOUR LIFETIME. WE HAVE THE RIGHT TO CHANGE PREMIUMS ONLY ON A CLASS BASIS BY STATE.**

**Medicare Supplement Policy** We Insure You, named as the Insured on the Policy Schedule. We promise to pay the benefits provided in this Policy for covered losses that are incurred while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached. **Notice to Buyer: This Policy may not cover all of Your medical expenses.**

**Your Thirty Day Right to Examine This Policy** If for any reason You are not satisfied with this Policy, You may return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all premiums You paid to Us and then You and We will be in the same position as if a Policy had never been issued.

**Coverage for Pre-existing Conditions** Benefits will be paid for all covered losses under this Policy, even those caused by a Sickness, Injury or physical condition that existed before the Effective Date of the Policy. Loss occurring during a Confinement is considered to commence with the first day of such Confinement.

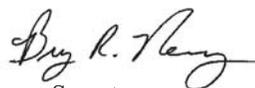
**Renewal Conditions** You may renew this Policy as long as You live. To renew, just pay a renewal premium. It must be paid on or before the end of the premium period, within the Grace Period, or during the Conservation Period. After this Policy is in force We cannot refuse to renew it or place any restrictions on it if the premium is paid on time.

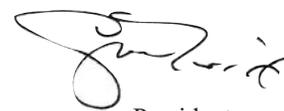
**Premium Changes** We will not change the premiums for this Policy during Your first year of coverage within the 90000 Series. Thereafter, we can change them, but only if We change them for all policies like Yours in Your state on a class basis. A class is determined by benefits selected, year of issue and/or your age at entry. No rate adjustment may be made on an individual basis. Notice will be given to You at least 31 days before any premium change.

Your Policy benefits automatically change in accordance with Policy provisions whenever Medicare benefits change. After Your first year of coverage, the renewal premium for this Policy may change on a renewal date following the Effective Date of any change in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. Any such premium change will be based on the actuarial computations that We then use to determine the renewal premium.

**Consideration & Effective Date** This Policy is issued in consideration of the statements in Your application for insurance that is attached to and is made a part of this Policy, and the payment of the initial premium. This payment will keep the Policy in force until the first renewal date. The initial premium and the first renewal date are shown on Page 2. Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown on Page 2. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.

  
Secretary

  
President

**POLICY SCHEDULE**

Plan: Policy Number:  
Insured: Effective Date:  
First Renewal Date:  
Initial Premium:  
Endorsements: Premium: See scale of attained age premiums on outline of coverage

**Renewal Premiums**

Annual                      Semi-Annual                      Quarterly                      Monthly Bank Draft

*You have selected Plan D, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

**61st to 90th Day  
Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.

**Lifetime  
Reserve  
Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.

**Following the  
Lifetime  
Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

**Part A & B  
Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

**Part B  
Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

## **ADDITIONAL BENEFITS**

**Medicare Part  
A Deductible** When You are confined as an inpatient to a Hospital, We will pay You the Medicare Part A Inpatient Hospital Deductible in any Medicare Benefit Period.

**Skilled Nursing  
Facility Benefit** We will pay You the actual billed charges up to the daily Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital skilled nursing facility care eligible under Medicare Part A.

**Medically  
Necessary  
Emergency  
Care in a  
Foreign  
Country** When You are traveling outside the United States and require Emergency Care, We will pay You 80% of the billed charges after a calendar year deductible of \$250. Emergency Care shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset beginning during the first 60 consecutive days of each trip outside the United States. Medical services must be of the type that Medicare would have covered if the care had been received in the United States. This benefit is subject to a lifetime maximum of \$50,000 dollars.

### ADDITIONAL BENEFITS (continued)

#### **At-Home Recovery Benefit**

We will pay You the actual charge, up to \$40 dollars per visit, for short term assistance with Activities of Daily Living furnished in Your Home by a Care Provider when you are recovering from a Sickness, Injury or surgery. You may receive up to 7 visits per week, with a calendar year maximum of 40 visits or \$1,600 dollars.

To receive benefits, Your Doctor must certify that the type and frequency of At-Home Recovery Visits are necessary because of a condition for which Your home care plan of treatment was approved by Medicare. All visits must be received during the period in which You are receiving Medicare approved home health care services, or within 8 weeks of the last date of service of a Medicare approved home health visit. In no event shall the total number of At-Home Recovery Visits exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

For purposes of this benefit, the following definitions shall apply:

(i) "Activities of Daily Living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings. (ii) "Care Provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry. (iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A Hospital or skilled nursing facility shall not be considered the insured's place of residence. (iv) "At-Home Recovery Visit" means the period of a visit required to provide At-Home Recovery Care, without limit on the duration of the visit, except each consecutive 4 hours in a 24 hour period of services provided by a Care Provider is one visit.

Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government program; and (ii) care provided by family members, unpaid volunteers or providers who are not Care Providers.

## DEFINITIONS

*The person named as the "Insured" on Page 2 of this Policy is referred to in this Policy as You, Your, Yours, or Insured and Heartland National Life Insurance Company as We, Our or Us.*

<b>Benefit Period</b>	Means a period that begins, after the Effective Date of this Policy, with the first day of Hospital Confinement and ends at the close of 60 consecutive days during which You were not confined to a Hospital or skilled nursing facility.
<b>Coinsurance</b>	Means the difference between the Medicare approved amount and the Medicare payment after You have satisfied the applicable Medicare deductibles.
<b>Confinement</b>	Means medically required stay as a resident inpatient in a Hospital or skilled nursing facility. It must be on the specific recommendation and under the general supervision of a Doctor.
<b>Doctor</b>	Means a duly licensed person practicing in the healing arts and acting within the scope of that license in treating a Sickness or Injury. A Doctor must be other than an immediate member of Your family.
<b>Hospital</b>	Means a place that is licensed as a Hospital pursuant to law and is legally operated for the care and treatment of sick or injured persons at their expense. A Hospital does not include the following kinds of facilities (including units in a Hospital used for such care); (a) convalescent, nursing home, rest home, or nursing care facilities; (b) places that primarily treat the aged, drug addicts or alcoholics; and (c) facilities that primarily provide custodial or educational care.
<b>Injury</b>	Means bodily harm sustained by You which: (a) is the direct result of an accident or trauma that occurs while Your Policy is in force; and (b) is not related to Sickness, bodily infirmity or any other cause.
<b>Inpatient Hospital Deductible</b>	Means the initial Hospital expense incurred during a Benefit Period for which You are responsible under Medicare.
<b>Medicare</b>	Means Title XVIII of the United States Social Security Act of 1965, as then constituted or later amended.
<b>Medicare Part A</b>	Means the program under Medicare officially called "Hospital Insurance Benefit for the Aged and Disabled".
<b>Medicare Part B</b>	Means the program under Medicare officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled".
<b>Medicare Eligible Expenses</b>	Means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
<b>Sickness</b>	Means illness or disease of an insured person.

## LIMITATIONS & EXCLUSIONS

<b>Limitations &amp; Exclusions</b>	We will not pay benefits under this Policy for: <ul style="list-style-type: none"><li>a) Any expense which is not eligible for payment under Medicare, unless otherwise covered in Your Policy or by optional endorsement; or</li><li>b) Any expense which You are not legally obligated to pay.</li></ul>
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## ELIGIBILITY FOR COVERAGE

<b>Individual Not Covered by Medicare</b>	If You have not established entitlement to benefits under Medicare, We will provide benefits under this Policy as though You had established entitlement.
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## POLICY SUSPENSION

<b>Medicaid Entitlement</b>	<p>If You apply for and become entitled to medical assistance under Medicaid, the benefits and premiums under Your Policy will be suspended, if requested, for up to 24 months during Your Medicaid Entitlement. You must request this suspension within 90 days of becoming entitled to Medicaid.</p> <p>If You lose Your entitlement to Medicaid while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Medicaid Entitlement and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Medicaid Entitlement is terminated.</p>
<b>Group Health Plan Coverage</b>	<p>If You were eligible for, and purchased this Policy by reason of disability and You become covered under an employer or union based group health plan, Your benefits and premiums under this Policy will be suspended, if requested, while You are covered under the group health plan.</p> <p>If You lose coverage under Your group health plan while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Group Health Plan Coverage and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Group Health Plan Coverage is terminated.</p>
<b>Reinstitution</b>	<p>Your reinstated Policy will provide the same or substantially equivalent coverage that was in effect when your Policy was suspended. The premium for Your reinstated Policy will be on the same terms that would have applied had Your Policy not been suspended.</p>

## GENERAL PROVISIONS

<b>Entire Contract; Changes</b>	<p>This Policy with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.</p>
<b>Conformity with State Laws</b>	<p>Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that Effective Date is amended to conform to the minimum requirements of such laws.</p>
<b>Misstatement of Age</b>	<p>If Your age has been misstated, We will pay only such amounts as the premium paid would have purchased at the correct age. In the event an age is overstated, We will refund any premium that may be due when We have been notified of this fact. If according to the correct age the Policy would not have become effective for any reason, Our liability shall be limited to the refund of the premium paid, subject to an adjustment for paid claims.</p>
<b>Notice of Claim</b>	<p>Written Notice of Claim must be given within 6 months after a covered loss begins or as soon as possible. The notice can be given to Us at the address shown on Page 8, or to any one of Our agents. The notice should include Your name and Policy number.</p>
<b>Claim Forms</b>	<p>When We receive Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not sent to You within 15 days after giving such notice, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.</p>
<b>Electronic Claim Filing Process</b>	<p>Your health care providers will usually submit electronically to Medicare the billed charges for any medical or Hospital expenses You incur. Medicare then processes the benefits for expenses eligible under Part A and/or B, and then passes Your claim electronically to Us for consideration of benefits under Your Policy. We will accept Medicare's electronic submission of Your claim to Us as Your Notice of Claim and Your Claim Form. For consideration of expenses that are not submitted electronically to Us, a paper copy of Your Medicare Summary Notice can serve as Your Notice of Claim and Claim Form. The Medicare Summary Notice shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare Summary Notice to Us or Your health care provider may submit it to Us on Your behalf.</p>
<b>Proofs of Loss</b>	<p>Written Proof of Loss must be given to Us within 90 days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.</p>

<b>Payment of Benefits</b>	All benefits will be paid to You, or Your assignee. Benefits unpaid at Your death may be paid to Your estate or We may pay up to \$1,000 to any relative of Yours who is entitled to them. Any payment made in good faith will fully release Us to the extent of that payment.
<b>Timely Payment of Benefits</b>	Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.
<b>Assignment</b>	No assignment of benefits under this Policy shall be binding upon Us unless the original (or copy of it) is on file with Us. We do not assume any responsibility for the validity of any assignment.
<b>Other Insurance With Us</b>	Your insurance under a like policy or policies with Us is limited to one such policy elected by You, Your beneficiary or Your estate, as the case may be, and We will return all premiums paid for all such other policies.
<b>Grace Period</b>	This Policy has a 31 day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period this Policy will stay in force.
<b>Conservation Period</b>	We offer You an additional 15 days beyond the Grace Period to pay Your premium. During this 15 day extension, this Policy is not in force unless Your premium is paid within this period. The Policy will then be renewed with no lapse in coverage.
<b>Unpaid Premium</b>	We reserve the right to deduct any premium due and unpaid from a claim payment.
<b>Reinstatement</b>	<p>If the renewal premium is not paid before the Grace Period ends or within the Conservation Period, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for Reinstatement will Reinstatement this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be Reinstated as of the approval date. Lacking such approval this Policy will be Reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.</p> <p>The Reinstated Policy will only cover losses that result from Injury or Sickness sustained after the date of Reinstatement. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any premium accepted with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.</p>
<b>Continuation of Coverage</b>	We cannot terminate Your Policy as long as You pay Your premium on time. Termination of coverage under this Policy shall be without prejudice to any continuous loss for Confinement to a Hospital or skilled nursing facility that commences while this Policy is in force and during which You are determined to be continuously totally disabled. In this Policy, "continuously totally disabled" means the complete inability of a person to engage in all the normal activities of a person of the same age and gender.
<b>Refund of Unearned Premium</b>	We will refund that part of any premium paid which covers a period beyond the end of the Policy month of Your death.
<b>Time Limit on Certain Defenses</b>	No statements, except fraudulent misstatements, made by You in the application for this Policy, shall be used to void this Policy or to deny a claim for loss incurred after 2 years from the Effective Date of this Policy. No claim for loss occurring after the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition had existed before the Effective Date of this Policy.
<b>Legal Action</b>	No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years after the time written Proof of Loss is required to be given.

**YOUR MEDICARE SUPPLEMENT POLICY**

If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.

If You have any questions about Your Policy, please write to Us and We will be happy to help You, or call Us, on Our toll free number listed above.

**Heartland National Life Insurance Company**  
**PO Box 2878**  
**Salt Lake City, Utah 84110-2878**

<p>Policy Benefits</p> <p style="padding-left: 20px;">Basic Benefits ..... Page 3</p> <p style="padding-left: 40px;">61st to 90th day</p> <p style="padding-left: 40px;">Lifetime Reserve</p> <p style="padding-left: 40px;">Following Lifetime Reserve</p> <p style="padding-left: 40px;">Part A &amp; B Blood</p> <p style="padding-left: 40px;">Part B Coinsurance</p> <p style="padding-left: 20px;">Additional Benefits (if any) ..... Page 3 &amp; 4</p> <p>Consideration ..... Page 1</p> <p>Coverage for Pre-existing Conditions ..... Page 1</p> <p>Definitions ..... Page 5</p> <p style="padding-left: 20px;">Benefit Period</p> <p style="padding-left: 20px;">Coinsurance</p> <p style="padding-left: 20px;">Confinement</p> <p style="padding-left: 20px;">Doctor</p> <p style="padding-left: 20px;">Hospital</p> <p style="padding-left: 20px;">Injury</p> <p style="padding-left: 20px;">Inpatient Hospital Deductible</p> <p style="padding-left: 20px;">Medicare</p> <p style="padding-left: 20px;">Medicare Part A</p> <p style="padding-left: 20px;">Medicare Part B</p> <p style="padding-left: 20px;">Medicare Eligible Expenses</p> <p style="padding-left: 20px;">Sickness</p> <p>Effective Date ..... Pages 1 &amp; 2</p>	<p>General Provisions ..... Pages 6 &amp; 7</p> <p style="padding-left: 20px;">Assignment</p> <p style="padding-left: 20px;">Claim Forms</p> <p style="padding-left: 20px;">Conformity with State Laws</p> <p style="padding-left: 20px;">Conservation Period</p> <p style="padding-left: 20px;">Continuation of Coverage</p> <p style="padding-left: 20px;">Electronic Claim Filing Process</p> <p style="padding-left: 20px;">Entire Contract; Changes</p> <p style="padding-left: 20px;">Grace Period</p> <p style="padding-left: 20px;">Legal Action</p> <p style="padding-left: 20px;">Misstatement of Age</p> <p style="padding-left: 20px;">Notice of Claim</p> <p style="padding-left: 20px;">Other Insurance with Us</p> <p style="padding-left: 20px;">Payment of Benefits</p> <p style="padding-left: 20px;">Proofs of Loss</p> <p style="padding-left: 20px;">Refund of Unearned Premium</p> <p style="padding-left: 20px;">Reinstatement</p> <p style="padding-left: 20px;">Time Limit on Certain Defenses</p> <p style="padding-left: 20px;">Timely Payment of Benefits</p> <p style="padding-left: 20px;">Unpaid Premium</p> <p>Individual Not Covered By Medicare ..... Page 5</p> <p>Limitations And Exclusions ..... Page 5</p> <p>Policy Suspension ..... Page 6</p> <p>Premium Changes ..... Page 1</p> <p>Renewal Conditions ..... Page 1</p> <p>Your Thirty Day Right to Examine This Policy ..... Page 1</p>
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**YOU HAVE SELECTED PLAN F. THIS POLICY PROVIDES BENEFITS WHICH SUPPLEMENT MEDICARE. IT IS GUARANTEED RENEWABLE FOR YOUR LIFETIME. WE HAVE THE RIGHT TO CHANGE PREMIUMS ONLY ON A CLASS BASIS BY STATE.**

**Medicare Supplement Policy** We Insure You, named as the Insured on the Policy Schedule. We promise to pay the benefits provided in this Policy for covered losses that are incurred while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached. **Notice to Buyer: This Policy may not cover all of Your medical expenses.**

**Your Thirty Day Right to Examine This Policy** If for any reason You are not satisfied with this Policy, You may return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all premiums You paid to Us and then You and We will be in the same position as if a Policy had never been issued.

**Coverage for Pre-existing Conditions** Benefits will be paid for all covered losses under this Policy, even those caused by a Sickness, Injury or physical condition that existed before the Effective Date of the Policy. Loss occurring during a Confinement is considered to commence with the first day of such Confinement.

**Renewal Conditions** You may renew this Policy as long as You live. To renew, just pay a renewal premium. It must be paid on or before the end of the premium period, within the Grace Period, or during the Conservation Period. After this Policy is in force We cannot refuse to renew it or place any restrictions on it if the premium is paid on time.

**Premium Changes** We will not change the premiums for this Policy during Your first year of coverage within the {90000} Series. Thereafter, we can change them, but only if We change them for all policies like Yours in Your state on a class basis. A class is determined by benefits selected, year of issue and/or your age at entry. No rate adjustment may be made on an individual basis. Notice will be given to You at least 31 days before any premium change.

Your Policy benefits automatically change in accordance with Policy provisions whenever Medicare benefits change. After Your first year of coverage, the renewal premium for this Policy may change on a renewal date following the Effective Date of any change in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. Any such premium change will be based on the actuarial computations that We then use to determine the renewal premium.

**Consideration & Effective Date** This Policy is issued in consideration of the statements in Your application for insurance that is attached to and is made a part of this Policy, and the payment of the initial premium. This payment will keep the Policy in force until the first renewal date. The initial premium and the first renewal date are shown on Page 2. Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown on Page 2. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.

  
Secretary

  
President

**POLICY SCHEDULE**

Plan: Policy Number:  
Insured: Effective Date:  
First Renewal Date:  
Initial Premium:  
Endorsements: Premium: See scale of attained age premiums on outline of coverage

**Renewal Premiums**

Annual                      Semi-Annual                      Quarterly                      Monthly Bank Draft

*You have selected Plan F, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

- 61st to 90th Day Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.
- Lifetime Reserve Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.
- Following the Lifetime Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

- Part A & B Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

- Part B Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

## **ADDITIONAL BENEFITS**

- Medicare Part A Deductible** When You are confined as an inpatient to a Hospital, We will pay You the Medicare Part A Inpatient Hospital Deductible in any Medicare Benefit Period.
- Medicare Part B Deductible** We will pay You for all Eligible Expenses used to satisfy Your Medicare Part B deductible amount per calendar year regardless of Hospital Confinement.
- 100% of the Medicare Part B Excess Charges** We will pay You 100% of the difference between the actual Medicare Part B billed charge, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.
- Medically Necessary Emergency Care in a Foreign Country** When You are traveling outside the United States and require Emergency Care, we will pay You 80% of the billed charges after a calendar year deductible of \$250. Emergency Care shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset beginning during the first 60 consecutive days of each trip outside the United States. Medical services must be of the type that Medicare would have covered if the care had been received in the United States. This benefit is subject to a lifetime maximum of \$50,000 dollars.

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## DEFINITIONS

*The person named as the "Insured" on Page 2 of this Policy is referred to in this Policy as You, Your, Yours, or Insured and Heartland National Life Insurance Company as We, Our or Us.*

<b>Benefit Period</b>	Means a period that begins, after the Effective Date of this Policy, with the first day of Hospital Confinement and ends at the close of 60 consecutive days during which You were not confined to a Hospital or skilled nursing facility.
<b>Coinsurance</b>	Means the difference between the Medicare approved amount and the Medicare payment after You have satisfied the applicable Medicare deductibles.
<b>Confinement</b>	Means medically required stay as a resident inpatient in a Hospital or skilled nursing facility. It must be on the specific recommendation and under the general supervision of a Doctor.
<b>Doctor</b>	Means a duly licensed person practicing in the healing arts and acting within the scope of that license in treating a Sickness or Injury. A Doctor must be other than an immediate member of Your family.
<b>Hospital</b>	Means a place that is licensed as a Hospital pursuant to law and is legally operated for the care and treatment of sick or injured persons at their expense. A Hospital does not include the following kinds of facilities (including units in a Hospital used for such care); (a) convalescent, nursing home, rest home, or nursing care facilities; (b) places that primarily treat the aged, drug addicts or alcoholics; and (c) facilities that primarily provide custodial or educational care.
<b>Injury</b>	Means bodily harm sustained by You which: (a) is the direct result of an accident or trauma that occurs while Your Policy is in force; and (b) is not related to Sickness, bodily infirmity or any other cause.
<b>Inpatient Hospital Deductible</b>	Means the initial Hospital expense incurred during a Benefit Period for which You are responsible under Medicare.
<b>Medicare</b>	Means Title XVIII of the United States Social Security Act of 1965, as then constituted or later amended.
<b>Medicare Part A</b>	Means the program under Medicare officially called "Hospital Insurance Benefit for the Aged and Disabled".
<b>Medicare Part B</b>	Means the program under Medicare officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled".
<b>Medicare Eligible Expenses</b>	Means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
<b>Sickness</b>	Means illness or disease of an insured person.

## LIMITATIONS & EXCLUSIONS

<b>Limitations &amp; Exclusions</b>	We will not pay benefits under this Policy for: <ul style="list-style-type: none"><li>a) Any expense which is not eligible for payment under Medicare, unless otherwise covered in Your Policy or by optional endorsement; or</li><li>b) Any expense which You are not legally obligated to pay.</li></ul>
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## ELIGIBILITY FOR COVERAGE

<b>Individual Not Covered by Medicare</b>	If You have not established entitlement to benefits under Medicare, We will provide benefits under this Policy as though You had established entitlement.
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## POLICY SUSPENSION

<b>Medicaid Entitlement</b>	<p>If You apply for and become entitled to medical assistance under Medicaid, the benefits and premiums under Your Policy will be suspended, if requested, for up to 24 months during Your Medicaid Entitlement. You must request this suspension within 90 days of becoming entitled to Medicaid.</p> <p>If You lose Your entitlement to Medicaid while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Medicaid Entitlement and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Medicaid Entitlement is terminated.</p>
<b>Group Health Plan Coverage</b>	<p>If You were eligible for, and purchased this Policy by reason of disability and You become covered under an employer or union based group health plan, Your benefits and premiums under this Policy will be suspended, if requested, while You are covered under the group health plan.</p> <p>If You lose coverage under Your group health plan while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Group Health Plan Coverage and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Group Health Plan Coverage is terminated.</p>
<b>Reinstitution</b>	<p>Your reinstated Policy will provide the same or substantially equivalent coverage that was in effect when your Policy was suspended. The premium for Your reinstated Policy will be on the same terms that would have applied had Your Policy not been suspended.</p>

## GENERAL PROVISIONS

<b>Entire Contract; Changes</b>	<p>This Policy with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.</p>
<b>Conformity with State Laws</b>	<p>Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that Effective Date is amended to conform to the minimum requirements of such laws.</p>
<b>Misstatement of Age</b>	<p>If Your age has been misstated, We will pay only such amounts as the premium paid would have purchased at the correct age. In the event an age is overstated, We will refund any premium that may be due when We have been notified of this fact. If according to the correct age the Policy would not have become effective for any reason, Our liability shall be limited to the refund of the premium paid, subject to an adjustment for paid claims.</p>
<b>Notice of Claim</b>	<p>Written Notice of Claim must be given within 6 months after a covered loss begins or as soon as possible. The notice can be given to Us at the address shown on Page 8, or to any one of Our agents. The notice should include Your name and Policy number.</p>
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<b>Electronic Claim Filing Process</b>	<p>Your health care providers will usually submit electronically to Medicare the billed charges for any medical or Hospital expenses You incur. Medicare then processes the benefits for expenses eligible under Part A and/or B, and then passes Your claim electronically to Us for consideration of benefits under Your Policy. We will accept Medicare's electronic submission of Your claim to Us as Your Notice of Claim and Your Claim Form. For consideration of expenses that are not submitted electronically to Us, a paper copy of Your Medicare Summary Notice can serve as Your Notice of Claim and Claim Form. The Medicare Summary Notice shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare Summary Notice to Us or Your health care provider may submit it to Us on Your behalf.</p>
<b>Proofs of Loss</b>	<p>Written Proof of Loss must be given to Us within 90 days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.</p>

<b>Payment of Benefits</b>	All benefits will be paid to You, or Your assignee. Benefits unpaid at Your death may be paid to Your estate or We may pay up to \$1,000 to any relative of Yours who is entitled to them. Any payment made in good faith will fully release Us to the extent of that payment.
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<b>Conservation Period</b>	We offer You an additional 15 days beyond the Grace Period to pay Your premium. During this 15 day extension, this Policy is not in force unless Your premium is paid within this period. The Policy will then be renewed with no lapse in coverage.
<b>Unpaid Premium</b>	We reserve the right to deduct any premium due and unpaid from a claim payment.
<b>Reinstatement</b>	<p>If the renewal premium is not paid before the Grace Period ends or within the Conservation Period, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for Reinstatement will Reinstatement this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be Reinstated as of the approval date. Lacking such approval this Policy will be Reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.</p> <p>The Reinstated Policy will only cover losses that result from Injury or Sickness sustained after the date of Reinstatement. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any premium accepted with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.</p>
<b>Continuation of Coverage</b>	We cannot terminate Your Policy as long as You pay Your premium on time. Termination of coverage under this Policy shall be without prejudice to any continuous loss for Confinement to a Hospital or skilled nursing facility that commences while this Policy is in force and during which You are determined to be continuously totally disabled. In this Policy, "continuously totally disabled" means the complete inability of a person to engage in all the normal activities of a person of the same age and gender.
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<b>Legal Action</b>	No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years after the time written Proof of Loss is required to be given.

**YOUR MEDICARE SUPPLEMENT POLICY**

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***YOU HAVE SELECTED PLAN G. THIS POLICY PROVIDES BENEFITS WHICH SUPPLEMENT MEDICARE. IT IS GUARANTEED RENEWABLE FOR YOUR LIFETIME. WE HAVE THE RIGHT TO CHANGE PREMIUMS ONLY ON A CLASS BASIS BY STATE.***

**Medicare Supplement Policy** We Insure You, named as the Insured on the Policy Schedule. We promise to pay the benefits provided in this Policy for covered losses that are incurred while this Policy is in force. All benefits are subject to the definitions, limitations, exclusions and all other provisions of this Policy. All benefits are also subject to the provisions of any endorsement which may be attached. **Notice to Buyer: This Policy may not cover all of Your medical expenses.**

**Your Thirty Day Right to Examine This Policy** If for any reason You are not satisfied with this Policy, You may return it to Us or to the agent who sold it to You within 30 days after You receive it. We will refund all premiums You paid to Us and then You and We will be in the same position as if a Policy had never been issued.

**Coverage for Pre-existing Conditions** Benefits will be paid for all covered losses under this Policy, even those caused by a Sickness, Injury or physical condition that existed before the Effective Date of the Policy. Loss occurring during a Confinement is considered to commence with the first day of such Confinement.

**Renewal Conditions** You may renew this Policy as long as You live. To renew, just pay a renewal premium. It must be paid on or before the end of the premium period, within the Grace Period, or during the Conservation Period. After this Policy is in force We cannot refuse to renew it or place any restrictions on it if the premium is paid on time.

**Premium Changes** We will not change the premiums for this Policy during Your first year of coverage within the 90000 Series. Thereafter, we can change them, but only if We change them for all policies like Yours in Your state on a class basis. A class is determined by benefits selected, year of issue and/or your age at entry. No rate adjustment may be made on an individual basis. Notice will be given to You at least 31 days before any premium change.

Your Policy benefits automatically change in accordance with Policy provisions whenever Medicare benefits change. After Your first year of coverage, the renewal premium for this Policy may change on a renewal date following the Effective Date of any change in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. Any such premium change will be based on the actuarial computations that We then use to determine the renewal premium.

**Consideration & Effective Date** This Policy is issued in consideration of the statements in Your application for insurance that is attached to and is made a part of this Policy, and the payment of the initial premium. This payment will keep the Policy in force until the first renewal date. The initial premium and the first renewal date are shown on Page 2. Coverage under this Policy begins at 12:01 a.m. Standard Time at Your residence on the Effective Date shown on Page 2. It ends, subject to the Grace Period, at 12:01 a.m. on the date any renewal premium is due and not paid.

IN WITNESS WHEREOF, We have caused the Policy to be signed by Our President and Secretary.

  
Secretary

  
President

**POLICY SCHEDULE**

Plan: Policy Number:  
Insured: Effective Date:  
First Renewal Date:  
Initial Premium:  
Endorsements: Premium: See scale of attained age premiums on outline of coverage

**Renewal Premiums**

Annual                      Semi-Annual                      Quarterly                      Monthly Bank Draft

*You have selected Plan G, which contains the following benefits. If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.*

## **BASIC BENEFITS**

### **Part A Hospital Expense Benefits**

- 61st to 90th Day Coinsurance** We will pay You the Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare Part A for each day You are hospitalized from the 61st day through the 90th day in any Medicare Benefit Period.
- Lifetime Reserve Coinsurance** We will pay You the Medicare Part A Eligible Expenses You incur as daily Hospital charges during use of Medicare's lifetime Hospital inpatient reserve days, to the extent not covered by Medicare.
- Following the Lifetime Reserve** Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, We will pay You 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Your provider shall accept Your payment as payment in full and will not bill You for any balance.

### **Part A & B Blood Benefits**

- Part A & B Blood Benefit** We will pay You for the first 3 pints of whole blood or equivalent packed red blood cells You are charged for when not paid by Medicare Part A or B each calendar year.

### **Part B Benefits**

- Part B Coinsurance** We will pay You the Coinsurance amount, or the copayment amount due for Hospital outpatient services under a prospective payment system (PPS), when as a result of Injury or Sickness, You incur Medicare Part B Eligible Expenses, regardless of Hospital Confinement.

## **ADDITIONAL BENEFITS**

- Medicare Part A Deductible** When You are confined as an inpatient to a Hospital, We will pay You the Medicare Part A Inpatient Hospital Deductible in any Medicare Benefit Period.
- Skilled Nursing Facility Benefit** We will pay You the actual billed charges up to the daily Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital skilled nursing facility care eligible under Medicare Part A.
- 80% of the Medicare Part B Excess Charges** We will pay You 80% of the difference between the actual Medicare Part B billed charge, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.
- Medically Necessary Emergency Care in a Foreign Country** When You are traveling outside the United States and require Emergency Care, we will pay You 80% of the billed charges after a calendar year deductible of \$250. Emergency Care shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset beginning during the first 60 consecutive days of each trip outside the United States. Medical services must be of the type that Medicare would have covered if the care had been received in the United States. This benefit is subject to a lifetime maximum of \$50,000 dollars.

**Benefits are continued on Page 4**

### ADDITIONAL BENEFITS (continued)

#### **At-Home Recovery Benefit**

We will pay You the actual charge, up to \$40 dollars per visit, for short term assistance with Activities of Daily Living furnished in Your Home by a Care Provider when you are recovering from a Sickness, Injury or surgery. You may receive up to 7 visits per week, with a calendar year maximum of 40 visits or \$1,600 dollars.

To receive benefits, Your Doctor must certify that the type and frequency of At-Home Recovery Visits are necessary because of a condition for which Your home care plan of treatment was approved by Medicare. All visits must be received during the period in which You are receiving Medicare approved home health care services, or within 8 weeks of the last date of service of a Medicare approved home health visit. In no event shall the total number of At-Home Recovery Visits exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

For purposes of this benefit, the following definitions shall apply:

(i) "Activities of Daily Living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings. (ii) "Care Provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry. (iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A Hospital or skilled nursing facility shall not be considered the insured's place of residence. (iv) "At-Home Recovery Visit" means the period of a visit required to provide At-Home Recovery Care, without limit on the duration of the visit, except each consecutive 4 hours in a 24 hour period of services provided by a Care Provider is one visit.

Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and (ii) care provided by family members, unpaid volunteers or providers who are not Care Providers.

## DEFINITIONS

*The person named as the "Insured" on Page 2 of this Policy is referred to in this Policy as You, Your, Yours, or Insured and Heartland National Life Insurance Company as We, Our or Us.*

<b>Benefit Period</b>	Means a period that begins, after the Effective Date of this Policy, with the first day of Hospital Confinement and ends at the close of 60 consecutive days during which You were not confined to a Hospital or skilled nursing facility.
<b>Coinsurance</b>	Means the difference between the Medicare approved amount and the Medicare payment after You have satisfied the applicable Medicare deductibles.
<b>Confinement</b>	Means medically required stay as a resident inpatient in a Hospital or skilled nursing facility. It must be on the specific recommendation and under the general supervision of a Doctor.
<b>Doctor</b>	Means a duly licensed person practicing in the healing arts and acting within the scope of that license in treating a Sickness or Injury. A Doctor must be other than an immediate member of Your family.
<b>Hospital</b>	Means a place that is licensed as a Hospital pursuant to law and is legally operated for the care and treatment of sick or injured persons at their expense. A Hospital does not include the following kinds of facilities (including units in a Hospital used for such care); (a) convalescent, nursing home, rest home, or nursing care facilities; (b) places that primarily treat the aged, drug addicts or alcoholics; and (c) facilities that primarily provide custodial or educational care.
<b>Injury</b>	Means bodily harm sustained by You which: (a) is the direct result of an accident or trauma that occurs while Your Policy is in force; and (b) is not related to Sickness, bodily infirmity or any other cause.
<b>Inpatient Hospital Deductible</b>	Means the initial Hospital expense incurred during a Benefit Period for which You are responsible under Medicare.
<b>Medicare</b>	Means Title XVIII of the United States Social Security Act of 1965, as then constituted or later amended.
<b>Medicare Part A</b>	Means the program under Medicare officially called "Hospital Insurance Benefit for the Aged and Disabled".
<b>Medicare Part B</b>	Means the program under Medicare officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled".
<b>Medicare Eligible Expenses</b>	Means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
<b>Sickness</b>	Means illness or disease of an insured person.

## LIMITATIONS & EXCLUSIONS

<b>Limitations &amp; Exclusions</b>	We will not pay benefits under this Policy for: <ul style="list-style-type: none"><li>a) Any expense which is not eligible for payment under Medicare, unless otherwise covered in Your Policy or by optional endorsement; or</li><li>b) Any expense which You are not legally obligated to pay.</li></ul>
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## ELIGIBILITY FOR COVERAGE

<b>Individual Not Covered by Medicare</b>	If You have not established entitlement to benefits under Medicare, We will provide benefits under this Policy as though You had established entitlement.
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## POLICY SUSPENSION

<b>Medicaid Entitlement</b>	<p>If You apply for and become entitled to medical assistance under Medicaid, the benefits and premiums under Your Policy will be suspended, if requested, for up to 24 months during Your Medicaid Entitlement. You must request this suspension within 90 days of becoming entitled to Medicaid.</p> <p>If You lose Your entitlement to Medicaid while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Medicaid Entitlement and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Medicaid Entitlement is terminated.</p>
<b>Group Health Plan Coverage</b>	<p>If You were eligible for, and purchased this Policy by reason of disability and You become covered under an employer or union based group health plan, Your benefits and premiums under this Policy will be suspended, if requested, while You are covered under the group health plan.</p> <p>If You lose coverage under Your group health plan while Your Policy is suspended, Your Policy will be automatically reinstated if You request it within 90 days of losing Your Group Health Plan Coverage and You pay the premium attributable to this period. Your reinstated Policy will be effective as of the date Your Group Health Plan Coverage is terminated.</p>
<b>Reinstitution</b>	<p>Your reinstated Policy will provide the same or substantially equivalent coverage that was in effect when your Policy was suspended. The premium for Your reinstated Policy will be on the same terms that would have applied had Your Policy not been suspended.</p>

## GENERAL PROVISIONS

<b>Entire Contract; Changes</b>	<p>This Policy with endorsements and any attached papers, is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.</p>
<b>Conformity with State Laws</b>	<p>Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that Effective Date is amended to conform to the minimum requirements of such laws.</p>
<b>Misstatement of Age</b>	<p>If Your age has been misstated, We will pay only such amounts as the premium paid would have purchased at the correct age. In the event an age is overstated, We will refund any premium that may be due when We have been notified of this fact. If according to the correct age the Policy would not have become effective for any reason, Our liability shall be limited to the refund of the premium paid, subject to an adjustment for paid claims.</p>
<b>Notice of Claim</b>	<p>Written Notice of Claim must be given within 6 months after a covered loss begins or as soon as possible. The notice can be given to Us at the address shown on Page 8, or to any one of Our agents. The notice should include Your name and Policy number.</p>
<b>Claim Forms</b>	<p>When We receive Notice of Claim, We will send You forms for filing Proof of Loss. If these forms are not sent to You within 15 days after giving such notice, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.</p>
<b>Electronic Claim Filing Process</b>	<p>Your health care providers will usually submit electronically to Medicare the billed charges for any medical or Hospital expenses You incur. Medicare then processes the benefits for expenses eligible under Part A and/or B, and then passes Your claim electronically to Us for consideration of benefits under Your Policy. We will accept Medicare's electronic submission of Your claim to Us as Your Notice of Claim and Your Claim Form. For consideration of expenses that are not submitted electronically to Us, a paper copy of Your Medicare Summary Notice can serve as Your Notice of Claim and Claim Form. The Medicare Summary Notice shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare Summary Notice to Us or Your health care provider may submit it to Us on Your behalf.</p>
<b>Proofs of Loss</b>	<p>Written Proof of Loss must be given to Us within 90 days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.</p>

<b>Payment of Benefits</b>	All benefits will be paid to You, or Your assignee. Benefits unpaid at Your death may be paid to Your estate or We may pay up to \$1,000 to any relative of Yours who is entitled to them. Any payment made in good faith will fully release Us to the extent of that payment.
<b>Timely Payment of Benefits</b>	Benefits payable under this Policy will be paid as soon as We receive proper written Proof of Loss.
<b>Assignment</b>	No assignment of benefits under this Policy shall be binding upon Us unless the original (or copy of it) is on file with Us. We do not assume any responsibility for the validity of any assignment.
<b>Other Insurance With Us</b>	Your insurance under a like policy or policies with Us is limited to one such policy elected by You, Your beneficiary or Your estate, as the case may be, and We will return all premiums paid for all such other policies.
<b>Grace Period</b>	This Policy has a 31 day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period this Policy will stay in force.
<b>Conservation Period</b>	We offer You an additional 15 days beyond the Grace Period to pay Your premium. During this 15 day extension, this Policy is not in force unless Your premium is paid within this period. The Policy will then be renewed with no lapse in coverage.
<b>Unpaid Premium</b>	We reserve the right to deduct any premium due and unpaid from a claim payment.
<b>Reinstatement</b>	<p>If the renewal premium is not paid before the Grace Period ends or within the Conservation Period, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for Reinstatement will Reinstatement this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be Reinstated as of the approval date. Lacking such approval this Policy will be Reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval.</p> <p>The Reinstated Policy will only cover losses that result from Injury or Sickness sustained after the date of Reinstatement. In all other respects, Your rights and Our rights will remain the same after You have satisfied any provisions noted on or attached to the Reinstated Policy. Any premium accepted with a Reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of Reinstatement.</p>
<b>Continuation of Coverage</b>	We cannot terminate Your Policy as long as You pay Your premium on time. Termination of coverage under this Policy shall be without prejudice to any continuous loss for Confinement to a Hospital or skilled nursing facility that commences while this Policy is in force and during which You are determined to be continuously totally disabled. In this Policy, "continuously totally disabled" means the complete inability of a person to engage in all the normal activities of a person of the same age and gender.
<b>Refund of Unearned Premium</b>	We will refund that part of any premium paid which covers a period beyond the end of the Policy month of Your death.
<b>Time Limit on Certain Defenses</b>	No statements, except fraudulent misstatements, made by You in the application for this Policy, shall be used to void this Policy or to deny a claim for loss incurred after 2 years from the Effective Date of this Policy. No claim for loss occurring after the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition had existed before the Effective Date of this Policy.
<b>Legal Action</b>	No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required by this Policy. No such action may be brought after 3 years after the time written Proof of Loss is required to be given.

## YOUR MEDICARE SUPPLEMENT POLICY

If additional information is needed, please contact Your Heartland agent or call one of Our Policyowner Specialists at {1 (800) 916-7971}.

If You have any questions about Your Policy, please write to Us and We will be happy to help You, or call Us, on Our toll free number listed above.

**Heartland National Life Insurance Company**  
**PO Box 2878**  
**Salt Lake City, Utah 84110-2878**

<p>Policy Benefits</p> <p style="padding-left: 20px;">Basic Benefits ..... Page 3</p> <p style="padding-left: 40px;">61st to 90th day</p> <p style="padding-left: 40px;">Lifetime Reserve</p> <p style="padding-left: 40px;">Following Lifetime Reserve</p> <p style="padding-left: 40px;">Part A &amp; B Blood</p> <p style="padding-left: 40px;">Part B Coinsurance</p> <p style="padding-left: 40px;">Additional Benefits (if any) ..... Page 3 &amp; 4</p> <p>Consideration ..... Page 1</p> <p>Coverage for Pre-existing Conditions ..... Page 1</p> <p>Definitions ..... Page 5</p> <p style="padding-left: 20px;">Benefit Period</p> <p style="padding-left: 20px;">Coinsurance</p> <p style="padding-left: 20px;">Confinement</p> <p style="padding-left: 20px;">Doctor</p> <p style="padding-left: 20px;">Hospital</p> <p style="padding-left: 20px;">Injury</p> <p style="padding-left: 20px;">Inpatient Hospital Deductible</p> <p style="padding-left: 20px;">Medicare</p> <p style="padding-left: 20px;">Medicare Part A</p> <p style="padding-left: 20px;">Medicare Part B</p> <p style="padding-left: 20px;">Medicare Eligible Expenses</p> <p style="padding-left: 20px;">Sickness</p> <p>Effective Date ..... Pages 1 &amp; 2</p>	<p>General Provisions ..... Pages 6 &amp; 7</p> <p style="padding-left: 20px;">Assignment</p> <p style="padding-left: 20px;">Claim Forms</p> <p style="padding-left: 20px;">Conformity with State Laws</p> <p style="padding-left: 20px;">Conservation Period</p> <p style="padding-left: 20px;">Continuation of Coverage</p> <p style="padding-left: 20px;">Electronic Claim Filing Process</p> <p style="padding-left: 20px;">Entire Contract; Changes</p> <p style="padding-left: 20px;">Grace Period</p> <p style="padding-left: 20px;">Legal Action</p> <p style="padding-left: 20px;">Misstatement of Age</p> <p style="padding-left: 20px;">Notice of Claim</p> <p style="padding-left: 20px;">Other Insurance with Us</p> <p style="padding-left: 20px;">Payment of Benefits</p> <p style="padding-left: 20px;">Proofs of Loss</p> <p style="padding-left: 20px;">Refund of Unearned Premium</p> <p style="padding-left: 20px;">Reinstatement</p> <p style="padding-left: 20px;">Time Limit on Certain Defenses</p> <p style="padding-left: 20px;">Timely Payment of Benefits</p> <p style="padding-left: 20px;">Unpaid Premium</p> <p>Individual Not Covered By Medicare ..... Page 5</p> <p>Limitations And Exclusions ..... Page 5</p> <p>Policy Suspension ..... Page 6</p> <p>Premium Changes ..... Page 1</p> <p>Renewal Conditions ..... Page 1</p> <p>Your Thirty Day Right to Examine This Policy ..... Page 1</p>
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**PART I - MEDICARE & INSURANCE INFORMATION (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. Did you turn age 65 in the last six months?  Yes  No
- 2. Did you enroll in Medicare Part B in the last six months?  Yes  No

If "Yes", what is the effective date? --

- 3. 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

- 4. 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. (If you are still covered under the other policy, leave "END" blank.)

Start --      End --

- b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?  Yes  No
- c. Was this your first time in this type of Medicare plan?  Yes  No
- d. Did you drop a Medicare Supplement plan to enroll in the Medicare plan?  Yes  No

- 5. 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

- 6. 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 and what kind of policy?

b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

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 1-8 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 benefits; or 2) is primary to Medicare and the plan terminates or the plan ceases to provide all 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 circumstance 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, 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, a risk or cost contract, or a Medicare Select plan, 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 or PACE provider and then disenrolled within 12 months
- g. Terminated coverage under a Medicare Supplement policy that covers outpatient prescription drugs and enrolled in a Medicare Part D plan during the initial enrollment period.

**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

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 premiums 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.

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

**Fraud 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: --  
(Month/Day/Year)

Applicant's Signature: \_\_\_\_\_

Writing Agent's Signature: \_\_\_\_\_

Agent Number:

Mail policy to  Agent  Applicant



**Heartland National Life Insurance Company**  
**Outline Of Medicare Supplement Coverage - Cover Page: 1 of 2**  
**Benefit Plans A, D, F and G**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

**Basic Benefits For Plans A-J:** Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end; Medical Expenses - Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services; Blood - First three pints of blood each year.

A	B	C	D	E	F	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance			
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
				Preventive Care NOT Covered by Medicare						Preventive Care NOT Covered by Medicare

❖ Plans currently not available for sale

\* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year \$2,000 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

**Heartland National Life Insurance Company**  
**Outline Of Medicare Supplement Coverage - Cover Page: 2 of 2**

**Basic Benefits for Plans K and L:** Similar services as plans A - J, but cost sharing for the basic benefits is at different levels.

J❖	K**❖	L**❖
Basic Benefits	100% of Part A Hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 50% Hospice cost-sharing 50% of Medicare eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B Preventive Services	100% of Part A Hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 75% Hospice cost-sharing 75% of Medicare eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	\$[4,620] Out-of-Pocket Annual Limit***	[\$2,310] Out-of-Pocket Annual Limit***

❖ Plans currently not available for sale

\*\* Plans K and L provide for different cost-sharing for items and services than Plans A – J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges.” You will be responsible for paying excess charges.

\*\*\* The out-of-pocket annual limit will increase each year for inflation.

See the following Plan descriptions for details and exceptions.

**Preferred Premiums - Annual**  
**Zip Codes: 720-722**  
**Add a One-Time Policy Fee of \$25**

	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65+	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90

*Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12*

# Preferred Premiums - Annual

Zip Codes: 716-719, 723-729

Add a One-Time Policy Fee of \$25

	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65+	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00

*Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12*

**Standard Premiums - Annual**  
**Zip Codes: 720-722**  
**Add a One-Time Policy Fee of \$25**

	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65+	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30

*Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12*

**Standard Premiums - Annual**  
**Zip Codes: 716-719, 723-729**  
**Add a One-Time Policy Fee of \$25**

	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65+	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70

*Modal Factors: SA = Annual x.5, Q = Annual x.25, MBD= Annual ÷ 12*

### **PREMIUM INFORMATION**

We, Heartland National Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State. Each year following the changes in Medicare's deductibles and/or benefits your rates may be adjusted at that time. Your initial premiums are guaranteed for one full year.

### **DISCLOSURE PAGE**

Use this outline to compare benefits and premiums among policies.

### **READ YOUR POLICY VERY CAREFULLY**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

### **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to us at: PO Box 2878, Salt Lake City, Utah 84110-2878. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued, and return all of your payments.

### **POLICY REPLACEMENT**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

### **NOTICE**

This policy may not fully cover all of your medical costs.

Neither Heartland National Life nor its agents are connected with Medicare.

### **COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**PLAN A**  
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day  91st day and after: -While using 60 lifetime reserve days  -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but [\$1068]  All but [\$267] a day  All but [\$534] a day  \$0  \$0	\$0  [\$267] a day  [\$534] a day  100% of Medicare eligible expenses \$0	[\$1068] (Part A deductible)  \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$133.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**Plan A (continued)**  
**MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR**

*\*\*Once you have been billed [\$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT,</b> such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$131] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$135] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next [\$131] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$135] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Part A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [\$131] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$135] (Part B Deductible) \$0
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**PLAN D**  
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but [\$1068]  All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses \$0	\$0  \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

**MEDICARE (Part B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*\* Once you have been billed [\$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b> such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$135] of Medicare Approved Amounts ** Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$135] (Part B Deductible) \$0

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**Plan D (continued)**

<b>SERVICES (Medicare Part B, cont'd)</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next [\$135] of Medicare Approved Amounts**	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Part A & B**

<b>HOME HEALTH CARE</b>			
<b>MEDICARE APPROVED SERVICES</b>			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First [\$135] of Medicare Approved Amounts**	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</b>			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	\$0	Actual charges to \$40 a visit.	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved Visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	Balance
-Calendar Year Maximum	\$0	\$1600	Balance

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE,</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN F**  
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days  -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but [\$1068] All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses \$0	\$0 \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints  Additional amounts	\$0  100%	3 pints  \$0	\$0  \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**Plan F (continued)**  
**MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR**

*\*\*Once you have been billed [\$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 Generally 80%	[\$135] (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs [\$135] (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Part A & B**

<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b> -Medically necessary skilled care services and medical supplies -Durable medical equipment First [\$135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 [\$135] (Part B Deductible) 20%	\$0 \$0 \$0
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**Other Benefits - Not Covered by Medicare**

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> , Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**PLAN G**  
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but [\$1068] All but [\$267] a day All but [\$534] a day  \$0 \$0	[\$1068] (Part A deductible) [\$267] a day [\$534] a day  100% of Medicare eligible expenses \$0	\$0 \$0 \$0  \$0*** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

**MEDICARE (Part B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*\* Once you have been billed [\$135] of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b> such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$135] of Medicare Approved Amounts ** Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$135] (Part B Deductible) \$0

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**Plan G (continued)**

<b>SERVICES (Medicare Part B, cont'd)</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
Part B excess Charges (Above Medicare Approved Amounts)	\$0	80%	20%
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next [\$135] of Medicare Approved Amounts**	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Part A & B**

<b>HOME HEALTH CARE</b>			
<b>MEDICARE APPROVED SERVICES</b>			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First [\$135] of Medicare Approved Amounts**	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</b>			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	\$0	Actual charges to \$40 a visit.	Balance
-Number of visits covered (must be received with- in 8 weeks of last Medicare Approved Visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	Balance
-Calendar Year Maximum	\$0	\$1,600	Balance

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> , Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum



# HEARTLAND NATIONAL LIFE INSURANCE COMPANY ACTUARIAL MEMORANDUM

## Medicare Supplement Policy Forms 90000-A, 90000-D, 90000-F, and 90000-G Arkansas

### Scope and Purpose

The purpose of this filing is to demonstrate that the anticipated loss ratio of these forms meet the minimum requirements of your state. This Actuarial Memorandum is not intended to be used for any purpose other than described above.

### Description of Benefits

These policy forms are individual guaranteed renewable Medicare Supplement policy forms that meet the benefit requirements for these plans as defined by the NAIC Model regulation. A summary of the benefits follows:

<u>Policy Form</u>	<u>Plan</u>	<u>Benefit Description</u>
90000-A	A	Core Benefits*
90000-D	D	Core Benefits*, skilled nursing coinsurance, Part A deductible, foreign travel, at-home recovery
90000-F	F	Core Benefits*, skilled nursing coinsurance, Part A & Part B deductible, Part B Excess, foreign travel
90000-G	G	Core Benefits*, skilled nursing coinsurance, Part A deductible, Part B Excess (80%), foreign travel, at-home recovery

\*Core Benefits: Part A coinsurance plus 365 additional days after Medicare benefits end, Part B coinsurance, and the first 3 pints of blood each year.

### Morbidity

Claim costs are based on statistics provided from the following sources:

- 1.) American Academy of Actuaries Medicare Supplement Experience Report, June 2000
- 2.) Proprietary Medicare Supplement insurance client data and input from the Company's reinsurer

Selection Factors:

<u>Year</u>	<u>Factor</u>
1	0.930
2	1.015
3+	1.015

**Medical Trend**

Claim costs and premiums have been calculated at 2009 levels and the assumed future medical trend is 8.0% to account for medical provider reimbursements rate increases, utilization changes, medical cost shifting, and new medical procedures and technology.

**Mortality & Lapses Rates**

Mortality is calculated using the 2000 US Life Mortality Table

Voluntary lapses are based on the following table:

<u>Year</u>	<u>Issue Ages 65-72</u>	<u>Issue Ages 73+</u>
1	16.0%	14.0%
2	14.0%	12.0%
3	12.0%	10.0%

**Expenses Allowances**

Expenses:

Issue:	\$69.00 per policy issued 3.00% of 1 <sup>st</sup> year premium
Maintenance:	\$48.40 per policy in force
Overhead:	2.00% of premium
Premium Tax:	2.00% of premium

**Marketing Method**

This product will be marketed through agents and brokers on an individual basis.

**Gross Premium Structure**

Premium rates are based upon a zip code and preferred/standard rate structure. Gross annual premiums are shown in Exhibit 2. There is also a one-time policy fee of \$25 that is considered part of the premium for loss ratios calculations. There are no modal loadings.

**Issue Age Range**

These policy forms will be issued to all individuals age 65+ who are eligible for Medicare. They will also be issued to disabled individuals eligible for Medicare in those states where mandated by law.

**Underwriting**

The policy will be issued to persons eligible for Medicare based on limited underwriting with yes/no questions. Persons applying for coverage during the open enrollment period will not be underwritten and will be offered preferred rates.

**Distribution of Business**

<b>Issue Age</b>	<b>Distribution</b>	<b>Plan</b>	<b>Distribution</b>
65	20.0%	A	5%
66-67	20.0%	D	10%
68-70	20.0%	F	75%
71-75	17.5%	G	10%
76-80	15.0%		
81-85	5.0%		
86+	2.5%		

<b>Gender</b>	<b>Distribution</b>
Male	40%
Female	60%
<b>UW Class</b>	<b>Distribution</b>
Preferred	85%
Standard	15%

**Claim Liability and Reserves**

The claim reserves will be calculated based on a completion factor approach.

**Anticipated Lifetime Loss Ratio**

The lifetime loss ratio is calculated as the present value of incurred claims divided by the present value of earned premiums. An interest rate of 4.00% is used in the present value calculations. The anticipated loss ratio for these forms meets or exceeds 65%. Durational loss ratios are shown in Exhibit 1.

The overall anticipated lifetime loss ratio for this form and its riders exceeds the minimum standard set forth by the regulations of this state, as they apply to guaranteed renewable policy forms providing these types of benefits.

**Actuarial Certification**

I certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws of this State;
2. This rate filing complies with all appropriate Actuarial Standards of Practice, including Actuarial Standard of Practice #8, "Regulatory Filings for Rates and Financial Projections for Health Plans";
3. The premiums are reasonable in relation to the benefits provided; and the premium schedule is not excessive, inadequate, nor unfairly discriminatory.



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Bryan R. Neary FSA, MAAA  
CSG Actuarial, LLC  
January 16, 2009

**Heartland National Life Insurance Company**  
**Exhibit 1 - Durational Loss Ratios**

**Policy Form 90000-A**

<u>Duration</u>	<u>Earned Premium</u>	<u>Incurred Claims</u>	<u>Loss Ratio</u>
1	1,064,227	723,676	68.0%
2	944,993	709,995	75.1%
3	875,620	660,151	75.4%
4	823,923	621,127	75.4%
5	772,590	582,384	75.4%
6	719,914	542,646	75.4%
7	666,231	502,143	75.4%
8	613,797	462,586	75.4%
9	561,795	423,355	75.4%
10	510,375	384,565	75.3%
11	461,210	347,480	75.3%
12	412,715	310,913	75.3%
13	367,087	276,510	75.3%
14	324,092	244,095	75.3%
15	283,747	213,680	75.3%
16	246,464	185,576	75.3%
17	211,696	159,374	75.3%
18	180,172	135,620	75.3%
19	151,767	114,219	75.3%
20	126,416	95,123	75.2%
21	104,143	78,348	75.2%
22	84,655	63,675	75.2%
23	67,962	51,109	75.2%
24	53,786	40,439	75.2%
25	41,900	31,495	75.2%
26	32,156	24,165	75.1%
27	24,247	18,217	75.1%
28	17,981	13,506	75.1%
29	13,101	9,838	75.1%
30	9,370	7,035	75.1%
<b>PV @ 4.0%</b>	<b>\$8,038,230</b>	<b>\$5,979,953</b>	<b>74.4%</b>

**Heartland National Life Insurance Company**  
**Exhibit 1 - Durational Loss Ratios**

**Policy Form 90000-D**

<u>Duration</u>	<u>Earned Premium</u>	<u>Incurred Claims</u>	<u>Loss Ratio</u>
1	1,431,263	977,913	68.3%
2	1,284,163	964,404	75.1%
3	1,194,951	900,976	75.4%
4	1,129,838	851,820	75.4%
5	1,064,524	802,520	75.4%
6	996,654	751,314	75.4%
7	927,413	699,065	75.4%
8	858,824	647,311	75.4%
9	790,280	595,595	75.4%
10	722,114	544,167	75.4%
11	656,137	494,395	75.3%
12	590,811	445,128	75.3%
13	528,664	398,262	75.3%
14	469,588	353,715	75.3%
15	413,713	311,586	75.3%
16	361,546	272,257	75.3%
17	312,529	235,310	75.3%
18	267,667	201,500	75.3%
19	226,876	170,763	75.3%
20	190,149	143,093	75.3%
21	157,603	118,579	75.2%
22	128,811	96,897	75.2%
23	103,985	78,206	75.2%
24	82,775	62,240	75.2%
25	64,888	48,779	75.2%
26	50,113	37,662	75.2%
27	38,019	28,567	75.1%
28	28,373	21,313	75.1%
29	20,782	15,607	75.1%
30	14,913	11,196	75.1%
<b>PV @ 4.0%</b>	<b>\$11,197,612</b>	<b>\$8,338,638</b>	<b>74.5%</b>

**Heartland National Life Insurance Company**  
**Exhibit 1 - Durational Loss Ratios**

**Policy Form 90000-F**

<u>Duration</u>	<u>Earned Premium</u>	<u>Incurred Claims</u>	<u>Loss Ratio</u>
1	1,526,842	1,046,103	68.5%
2	1,368,914	1,028,703	75.1%
3	1,271,705	958,811	75.4%
4	1,199,939	904,641	75.4%
5	1,128,341	850,605	75.4%
6	1,054,534	794,923	75.4%
7	979,746	738,492	75.4%
8	905,934	682,803	75.4%
9	832,504	627,404	75.4%
10	759,789	572,547	75.4%
11	689,574	519,581	75.3%
12	620,348	467,374	75.3%
13	554,593	417,789	75.3%
14	492,203	370,745	75.3%
15	433,300	326,334	75.3%
16	378,372	284,925	75.3%
17	326,871	246,106	75.3%
18	279,777	210,614	75.3%
19	236,999	178,381	75.3%
20	198,524	149,395	75.3%
21	164,454	123,733	75.2%
22	134,351	101,064	75.2%
23	108,410	81,532	75.2%
24	86,262	64,861	75.2%
25	67,598	50,816	75.2%
26	52,188	39,222	75.2%
27	39,585	29,743	75.1%
28	29,534	22,186	75.1%
29	21,629	16,243	75.1%
30	15,519	11,651	75.1%
<b>PV @ 4.0%</b>	<b>\$11,845,816</b>	<b>\$8,823,688</b>	<b>74.5%</b>

**Heartland National Life Insurance Company**  
**Exhibit 1 - Durational Loss Ratios**

**Policy Form 90000-G**

<u>Duration</u>	<u>Earned Premium</u>	<u>Incurred Claims</u>	<u>Loss Ratio</u>
1	1,431,263	977,913	68.3%
2	1,284,163	964,404	75.1%
3	1,194,951	900,976	75.4%
4	1,129,838	851,820	75.4%
5	1,064,524	802,520	75.4%
6	996,654	751,314	75.4%
7	927,413	699,065	75.4%
8	858,824	647,311	75.4%
9	790,280	595,595	75.4%
10	722,114	544,167	75.4%
11	656,137	494,395	75.3%
12	590,811	445,128	75.3%
13	528,664	398,262	75.3%
14	469,588	353,715	75.3%
15	413,713	311,586	75.3%
16	361,546	272,257	75.3%
17	312,529	235,310	75.3%
18	267,667	201,500	75.3%
19	226,876	170,763	75.3%
20	190,149	143,093	75.3%
21	157,603	118,579	75.2%
22	128,811	96,897	75.2%
23	103,985	78,206	75.2%
24	82,775	62,240	75.2%
25	64,888	48,779	75.2%
26	50,113	37,662	75.2%
27	38,019	28,567	75.1%
28	28,373	21,313	75.1%
29	20,782	15,607	75.1%
30	14,913	11,196	75.1%
<b>PV @ 4.0%</b>	<b>\$11,197,612</b>	<b>\$8,338,638</b>	<b>74.5%</b>

**Heartland - Form 90000 Attained Age Rates**

**State: AR Zip Codes: 720-722 Preferred**

**Add a One-Time Policy Fee of \$25**

Age	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
66	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
67	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
68	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
69	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
70	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
71	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
72	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
73	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
74	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
75	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
76	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
77	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
78	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
79	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
80	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
81	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
82	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
83	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
84	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
85	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
86	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
87	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
88	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
89	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
90	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
91	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
92	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
93	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
94	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
95	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
96	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
97	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
98	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90
99	1,110.40	1,110.40	1,464.90	1,464.90	1,600.60	1,600.60	1,496.90	1,496.90

Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12

Heartland - Form 90000 Attained Age Rates								
State: AR Zip Codes: 716-719, 723-729 Preferred								
Add a One-Time Policy Fee of \$25								
Age	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
66	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
67	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
68	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
69	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
70	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
71	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
72	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
73	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
74	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
75	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
76	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
77	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
78	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
79	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
80	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
81	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
82	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
83	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
84	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
85	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
86	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
87	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
88	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
89	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
90	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
91	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
92	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
93	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
94	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
95	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
96	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
97	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00

<b>98</b>	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00
<b>99</b>	958.50	958.50	1,264.50	1,264.50	1,381.60	1,381.60	1,292.00	1,292.00

Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12

**Heartland - Form 90000 Attained Age Rates**

**State: AR Zip Codes: 720-722 Standard**

**Add a One-Time Policy Fee of \$25**

Age	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
66	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
67	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
68	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
69	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
70	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
71	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
72	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
73	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
74	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
75	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
76	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
77	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
78	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
79	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
80	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
81	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
82	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
83	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
84	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
85	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
86	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
87	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
88	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
89	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
90	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
91	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
92	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
93	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
94	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
95	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
96	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
97	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
98	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30
99	1,233.50	1,233.50	1,628.00	1,628.00	1,778.40	1,778.40	1,663.30	1,663.30

Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12

Heartland - Form 90000 Attained Age Rates								
State: AR Zip Codes: 716-719, 723-729 Standard								
Add a One-Time Policy Fee of \$25								
Age	Plan A		Plan D		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male
65	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
66	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
67	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
68	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
69	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
70	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
71	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
72	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
73	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
74	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
75	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
76	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
77	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
78	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
79	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
80	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
81	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
82	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
83	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
84	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
85	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
86	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
87	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
88	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
89	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
90	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
91	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
92	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
93	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
94	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
95	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
96	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
97	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70

<b>98</b>	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70
<b>99</b>	1,064.70	1,064.70	1,405.20	1,405.20	1,535.10	1,535.10	1,435.70	1,435.70

Modal Factors: SA = Annual x.5, Q = Annual x.25, Monthly= Annual ÷ 12