

SERFF Tracking Number: ANTX-126455149 State: Arkansas
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 44587
 Company Tracking Number:
 TOI: H13G Group Health - Short Term Care Sub-TOI: H13G.001 Home Health Care
 Product Name: RCAPP10ANDSLHHCR0912
 Project Name/Number: RCAPP10ANDSLHHCR0912/RCAPP10ANDSLHHCR0912

Filing at a Glance

Company: Standard Life and Accident Insurance Company

Product Name: RCAPP10ANDSLHHCR0912 SERFF Tr Num: ANTX-126455149 State: Arkansas
 TOI: H13G Group Health - Short Term Care SERFF Status: Closed-Approved- State Tr Num: 44587
 Closed

Sub-TOI: H13G.001 Home Health Care Co Tr Num: State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Author: Sherry Wiegman Disposition Date: 01/21/2010
 Date Submitted: 01/14/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: RCAPP10ANDSLHHCR0912
 Project Number: RCAPP10ANDSLHHCR0912
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 01/21/2010

Status of Filing in Domicile: Not Filed
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Group
 Group Market Size: Small and Large
 Group Market Type: Association
 Explanation for Other Group Market Type:
 State Status Changed: 01/21/2010
 Created By: Sherry Wiegman
 Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Sherry Wiegman

Filing Description:

Attached for your review and approval is a new optional Home Health Care Rider and a revised product application with corresponding actuarial information. The Home Health Care Rider is a new form and the application will replace a previously approved application (form RCAPP08AR). This submission is new and has not been previously reviewed or rejected.

The Home Health Care Rider is optional and will provide home health care benefits when chosen by an insured/applicant as stated in the Rider. This Rider will be used in conjunction with a previously approved short term nursing facility product (form 2089C-0806-AR).

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The application will be used with the previously approved nursing facility product and will replace the current application (form RCAPP08AR) approved for use on June 25, 2008. The prior application was revised by the addition of the Home Health Care Rider option, etc.

This product will initially be marketed to ages 50 - 79 by licensed agents to members of the Policyholder.

We trust this information is complete and look forward to receiving your favorable reply.

Company and Contact

Filing Contact Information

Sherry Wiegman, Sr. Compliance Analyst sherry.wiegman@anico.com
 One Moody Plaza 17th Floor 409-621-7779 [Phone]
 Galveston, TX 77550 409-766-2950 [FAX]

Filing Company Information

Standard Life and Accident Insurance Company CoCode: 86355 State of Domicile: Oklahoma
 One Moody Plaza 17th Floor Group Code: 408 Company Type: Health Insurance
 Galveston, TX 77550 Group Name: State ID Number:
 (409) 621-7779 ext. [Phone] FEIN Number: 73-0994234

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Life and Accident Insurance Company	\$100.00	01/14/2010	33537686

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/21/2010	01/21/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Optional Rider	Sherry Wiegman	01/15/2010	01/15/2010

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Disposition

Disposition Date: 01/21/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form (revised)	Optional Rider	Approved-Closed	Yes
Form	Optional Rider	Replaced	Yes

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Amendment Letter

Submitted Date: 01/15/2010

Comments:

We identified an error in the TOI and revised the description. Thank you.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
SL-HHCR-0912	Certificate Amendment, Rider	Optional Insert Page, Endorsement or Rider	Initial				50.100	HOME HEALTH CARE RIDER 12-22-09.pdf

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Form Schedule

Lead Form Number: RCAPP10

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/21/2010	RCAPP10	Application/ Enrollment Form	Application	Revised	Replaced Form #: RCAPP08AR Previous Filing #: 06/25/2008	50.100	APPLICATION 1-12-10 W HHC.pdf
Approved-Closed 01/21/2010	SL-HHCR-0912	Certificate Amendment, Insert Page, Endorsement or Rider	Optional Rider	Initial		50.100	HOME HEALTH CARE RIDER 12-22-09.pdf

RECOVERY CARE II APPLICATION - ASSOCIATION MEMBER (Please Print - Black Ink)

SECTION A

1. Applicant _____ Date of Birth _____ Age _____
First Name Middle Initial Last Name
 Home Address _____ City _____ State _____ Zip _____
 Phone (____) _____ Best Time to Call _____ Email _____
2. Billing Address (if different) _____ City _____ State _____ Zip _____
3. Height _____ Weight _____

SECTION B

- New Policy Reinstatement
4. Male Female
5. **I, AS A MEMBER OF THE ASSOCIATION, AM APPLYING FOR:**
- a) Daily Benefit \$ _____ b) Lifetime Maximum Benefit Period (days): 180 270 360
- c) Elimination Period (days): 0 20 d) Inflation Protection Rider: Compound Simple
- e) Home Health Care Rider (if Inflation Protection Rider included in Base Plan, must also be included in Home Health Care Rider)
6. **Payment Mode:** Annual Semi-Annual Quarterly Monthly PAC
7. **Requested Effective Date:** _____

SECTION C

If the answer to any question in Section C (8-11h) is Yes, the application should not be submitted.

8. Are you now bedridden, confined to a nursing home, assisted living facility or hospital, or receiving the services of a home health care agency?..... Yes No
9. Within the past **10 years**, have you been treated for or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection? ... Yes No
10. Within the past **2 years**, have you:
- a) had or been recommended to have medical tests or treatment or surgery which have not been done or for which results have not been given? Yes No
- b) been hospitalized 2 or more times or confined to a nursing home or required assistance or supervision by another person for dressing, eating, personal hygiene (bathing or toileting), walking or transferring to or from a bed or chair or suffered a fracture of the spine or hip?..... Yes No
- c) required the use of a wheelchair, walker or cane? Yes No
- d) been advised to have cataract surgery or other eye surgery that has not been performed? Yes No

11. Do you now have or within the past **2 years** have you had or been advised to have treatment, surgery or to take prescription medication for:
- a) cancer (excluding basal or squamous cell), Hodgkin's disease, leukemia, or melanoma; even if the conditions are in remission? Yes No
 - b) congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder, heart disease, enlarged heart, transient ischemic attack, stroke, heart or heart valve surgery, angioplasty, pacemaker, or stent placement? Yes No
 - c) uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene? Yes No
 - d) emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen?..... Yes No
 - e) ulcerative colitis, Crohn's disease, cirrhosis of the liver, hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment?..... Yes No
 - f) Paget's disease, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder? Yes No
 - g) mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders or alcohol or drug abuse?..... Yes No
 - h) incontinence, any ostomy present due to disease, an organ transplant other than corneal? Yes No
12. Within the past **2 years**, have you consulted a physician, been diagnosed or received treatment for any condition not listed above, including dizziness, vertigo, tremors, seizures, depression, anxiety, amputation, arthritis, asthma, osteoporosis, urinary incontinence, heart rhythm disorders, heart bypass or heart attack?..... Yes No
- If Yes, give information regarding diagnosis or condition. (use additional sheet if necessary) _____

SECTION D

- Will any health, recovery short term, long term, or home health care insurance be replaced with this certificate? Yes No
- If Yes, which company? _____ Policy Number _____
- If Yes, read and complete the Notice to Applicant Regarding Replacement.

SECTION E

AGREEMENT — I have read or had read to me my completed application. My answers are true and complete to the best of my knowledge and belief. I understand my coverage, if issued, will begin on the date of issue shown in my certificate. I realize any false statement or misrepresentation in my application may result in loss of coverage under my certificate.

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.

ACKNOWLEDGMENT — If Medicare eligible, I have received the *Guide to Health Insurance for People with Medicare* and a Duplication of Medicare Coverage form from the Agent.

The certificate provides limited benefits. Review your certificate carefully.

Applicant's Signature _____ Date _____

City _____ State _____ Zip _____

A TELEPHONE INTERVIEW WILL BE CONDUCTED.

What will be the best time to contact the Applicant for the telephone interview? _____

**AUTHORIZATION TO OBTAIN, RELEASE
AND DISCLOSE MEDICAL INFORMATION**

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY's or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that:

1. such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
3. a picture copy or photocopy of this authorization shall be as valid as the original; and
4. any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

(Turn over to continue)

**AUTHORIZATION TO OBTAIN, RELEASE
AND DISCLOSE MEDICAL INFORMATION *(continued)***

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

Date

Applicant's Signature

Witness

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian-in-fact, guardian, payee representative or other



DISCLOSURE NOTICE

In connection with your application, Standard Life and Accident Insurance Company (Standard Life), or its reinsurers, may obtain medical and other information for evaluation purposes. Standard Life may obtain that information from the Medical Information Bureau, Inc. or any medical professional, medically related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given you or your family. That information could concern drugs, alcoholism or mental illness. Standard Life may also obtain an investigative consumer report on you.

Medical Information Bureau (MIB) Pre-notification – Information regarding your insurability will be treated as confidential. Standard Life or its reinsurers may, however, make a brief report thereon to 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. 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of the 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, Massachusetts 02184-8734.

Standard Life, or its reinsurers, may also release information from 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification – Federal and state laws require notification that, with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or for the appropriate fee, receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics, and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors, or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs if any, living conditions and type of community.

Standard Life and Accident Insurance Company

P.O. Box 696870, San Antonio, Texas 78269

888.350.1488

RECEIPT

IF PREMIUM IS COLLECTED, CHECK OR MONEY ORDER FOR INITIAL PREMIUM MUST ACCOMPANY APPLICATION. ALL CHECKS AND MONEY ORDERS MUST BE PAYABLE TO STANDARD LIFE AND ACCIDENT INSURANCE COMPANY.

If coverage is not issued, the initial premium will be refunded to the Applicant. If coverage is issued, it will begin on the date of issue shown in the certificate.

Received from _____

on _____

Date

an application for _____ Recovery Care II

and a Check Money Order

for \$ _____

Applicant's Signature

Agent's Signature



Standard Life and Accident Insurance Company

P.O. Box 696870, San Antonio, Texas 78269

888.350.1488



A Member of the American National Family of Companies
Administrative Office: One Moody Plaza, Galveston, Texas 77550
1-888-350-1488

HOME HEALTH CARE RIDER

In consideration of timely payment of additional premium, this Home Health Care Rider is added to and made a part of your insurance Certificate on the Home Health Care Rider Effective Date shown in the Schedule of Benefits, subject to all terms and conditions stated in the Policy and Certificate which do not conflict with the provisions of this Rider. The premium for this Rider is shown in the Certificate Schedule of Benefits.

As used in this Rider:

“Home Health Care” means a program of professional, paraprofessional or skilled care for medical services provided through a Home Health Care Agency to a patient in his or her home. This includes any of the following services:

1. Nursing services provided by a:
 - (a) registered nurse;
 - (b) licensed practical nurse;
 - (c) licensed vocational nurse; or
 - (d) a licensed public health nurse;
2. Physical therapy;
3. Speech therapy;
4. Respiratory therapy; or
5. Occupational therapy.

“Home Health Care” does not include services provided to a patient while confined in a Hospital, Nursing Facility, Assisted Living Facility or any other facility which makes a charge for room and board. Home Health Care does not include Homemaker Services.

“Home Health Care Agency” means an agency or organization which provides Home Health Care services, and:

1. Is licensed or certified, if required by the jurisdiction in which it is located; or accredited by:
 - (a) the National Home Caring Council, a Division of the Foundation for Hospice and Home Care;
 - (b) the Joint Commission Accreditation of Health Care Organizations; or
 - (c) the National League for Nursing;
2. Is supervised by a qualified professional such as a registered nurse or a licensed social worker;
3. Whose employees receive appropriate specialized training; and
4. Keeps clinical records, including Physician’s orders where appropriate, on all patients.

“Homemaker Services” means services that are provided by persons without professional skills or training, who may or may not be working under the supervision of a Home Health Care Agency. “Homemaker Services” may include meal preparation, light housekeeping (such as care and cleaning of the house, clothing and linens), shopping for food and other personal items, and providing transportation to essential service facilities.

“Lifetime Home Health Care Benefit” means the total number of days of Home Health Care benefits payable under the Certificate. The Lifetime Home Health Care Benefit is shown in the Certificate Schedule of Benefits. Once the Lifetime Home Health Care Benefit is met, no further benefits are payable and coverage under this Rider terminates.

“Maximum Home Health Care Daily Benefit” means the maximum amount payable for Home Health Care services in each 24 hour calendar day. The Maximum Home Health Care Daily Benefit is shown in the Certificate Schedule of Benefits. In no event will the Maximum Home Health Care Daily Benefit payable for covered services exceed the actual daily charge.

Eligibility for Benefits

You are eligible to receive benefits if all of the following requirements are met:

1. You are unable to perform, without Hands-on-Assistance, at least two (2) ADLs, as defined in the Policy, due to loss of functional capacity or You have suffered a Cognitive Impairment and require Home Health Care;
2. You would otherwise require a stay in a Hospital, Nursing Facility, Assisted Living Facility or any other facility for which room and board is charged;
3. The Home Health Care is Medically Necessary; and
4. The Home Health Care is prescribed in a plan of care by Your Physician.

Home Health Care services must begin after the Effective Date of this Rider and be provided while coverage is in force.

Benefit Information

We will pay up to the Maximum Home Health Care Daily Benefit for each day you incur Home Health Care charges provided by a Home Health Care Agency, subject to the Lifetime Home Health Care Benefit amount shown in the Certificate Schedule of Benefits.

Home Health Care benefits are not provided for Homemaker Services.

If a Compound Inflation Protection Rider or a Simple Inflation Protection Rider are in effect concurrently with this Rider and shown on the Schedule of Benefits, the amount of the Maximum Home Health Care Daily Benefit will be adjusted on the same basis as the Maximum Daily Benefit Amount for Nursing Facility care.

Premium payments due for this Rider will be waived while Home Health Care benefits are payable. Premium payments for this Rider will resume in accordance with the Policy provisions when You are no longer receiving Home Health Care.

This Rider is not subject to any other benefits of the Policy, including the Restoration Benefit.

Termination

This rider terminates on the earliest of the following:

1. the date Your coverage expires;
2. the date the Lifetime Home Health Care Benefit is met;
3. when the required premium is not paid within the grace period; or
4. the premium due date on or next following the date we receive Your written request to terminate this rider.

Except as stated in this Rider, nothing contained in this Rider will be held to change, waive or extend any provisions of the Policy or Certificate.



Secretary

Annual Premium

Home Health Care Rider:

[\$00.00]

Home Health Care Rider Effective Date:

[January 1, 2010]

Maximum Home Health Care Daily Benefit

**[75% of the Nursing Facility
Maximum Daily Benefit Amount]**

Lifetime Home Health Care Benefit

[90 Days]

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Supporting Document Schedules

	Item Status:	Status
Satisfied - Item: Flesch Certification	Approved-Closed	01/21/2010
Comments:		
Attachment: Readability Certification HHCR.pdf		



READABILITY CERTIFICATION

We hereby certify that SL-HCCR-0912 and RCAPP10 have achieved a Flesch scale readability score which meets the minimum reading ease score as required by the state of Arkansas.

A handwritten signature in black ink, appearing to read "James P. Stelling".

James P. Stelling.
Asst. Vice President, Health Compliance

01/14/2010

Date of Signature

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Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/14/2010	Form	Optional Rider	01/15/2010	HOME HEALTH CARE RIDER 12-22-09.pdf