

SERFF Tracking Number: PHYS-126441735 State: Arkansas
Filing Company: Physicians Mutual Insurance Company State Tracking Number: 44476
Company Tracking Number:
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.003 Other
Product Name: LTC FORMS
Project Name/Number: LTC FORMS/LTC FORMS

Filing at a Glance

Company: Physicians Mutual Insurance Company

Product Name: LTC FORMS SERFF Tr Num: PHYS-126441735 State: Arkansas
TOI: LTC03I Individual Long Term Care SERFF Status: Closed-Approved State Tr Num: 44476
Sub-TOI: LTC03I.003 Other Co Tr Num: State Status: Closed
Filing Type: Form Reviewer(s): Harris Shearer
Author: Kathryn Gurnett Disposition Date: 01/25/2010
Date Submitted: 01/05/2010 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: LTC FORMS Status of Filing in Domicile: Not Filed
Project Number: LTC FORMS Date Approved in Domicile:
Requested Filing Mode: Informational 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: 01/25/2010 Explanation for Other Group Market Type:
State Status Changed: 01/25/2010
Deemer Date: Created By: Kathryn Gurnett
Submitted By: Kathryn Gurnett Corresponding Filing Tracking Number:
Filing Description:
RE: NAIC - #80578 FEIN - 47-0270450
Physicians Mutual Insurance Company
Individual Long Term Care
A-LTC-RFAR - LTC Application
PM1993 - Personal Worksheet
Informational Filing

The above captioned forms are being sent to you for informational purposes and replace forms previously approved by your department. The A-LTC-RFAR and PM1993 were approved by your department on August 11, 2004.

The only revision to these forms is changing the word "Agent" to "Producer" so it would coincide with our advertising.

SERFF Tracking Number: *PHYS-126441735* State: *Arkansas*
Filing Company: *Physicians Mutual Insurance Company* State Tracking Number: *44476*
Company Tracking Number:
TOI: *LTC03I Individual Long Term Care* Sub-TOI: *LTC03I.003 Other*
Product Name: *LTC FORMS*
Project Name/Number: *LTC FORMS/LTC FORMS*
Per Company: *No*

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Physicians Mutual Insurance Company	\$40.00	01/05/2010	33260684
Physicians Mutual Insurance Company	\$60.00	01/22/2010	33712225

SERFF Tracking Number: *PHYS-126441735* State: *Arkansas*
 Filing Company: *Physicians Mutual Insurance Company* State Tracking Number: *44476*
 Company Tracking Number:
 TOI: *LTC03I Individual Long Term Care* Sub-TOI: *LTC03I.003 Other*
 Product Name: *LTC FORMS*
 Project Name/Number: *LTC FORMS/LTC FORMS*

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Harris Shearer	01/25/2010	01/25/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Fee	Note To Filer	Harris Shearer	01/22/2010	01/22/2010

SERFF Tracking Number: *PHYS-126441735* State: *Arkansas*
Filing Company: *Physicians Mutual Insurance Company* State Tracking Number: *44476*
Company Tracking Number:
TOI: *LTC03I Individual Long Term Care* Sub-TOI: *LTC03I.003 Other*
Product Name: *LTC FORMS*
Project Name/Number: *LTC FORMS/LTC FORMS*

Disposition

Disposition Date: 01/25/2010

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *PHYS-126441735* State: *Arkansas*
 Filing Company: *Physicians Mutual Insurance Company* State Tracking Number: *44476*
 Company Tracking Number:
 TOI: *LTC03I Individual Long Term Care* Sub-TOI: *LTC03I.003 Other*
 Product Name: *LTC FORMS*
 Project Name/Number: *LTC FORMS/LTC FORMS*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	LTC Partnership Certification		Yes
Form	APPLICATION		Yes
Form	PERSONAL WORKSHEET		Yes

SERFF Tracking Number: *PHYS-126441735* State: *Arkansas*
Filing Company: *Physicians Mutual Insurance Company* State Tracking Number: *44476*
Company Tracking Number:
TOI: *LTC03I Individual Long Term Care* Sub-TOI: *LTC03I.003 Other*
Product Name: *LTC FORMS*
Project Name/Number: *LTC FORMS/LTC FORMS*

Note To Filer

Created By:

Harris Shearer on 01/22/2010 10:25 AM

Last Edited By:

Harris Shearer

Submitted On:

01/25/2010 03:10 PM

Subject:

Filing Fee

Comments:

Effective 01/01/10, Arkansas Rule 57, Sec. 5, Subsection II requires a filing fee of \$50.00 per policy form or advertisement. The filing will be held pending receipt of the additional fees.

SERFF Tracking Number: *PHYS-126441735* State: *Arkansas*
 Filing Company: *Physicians Mutual Insurance Company* State Tracking Number: *44476*
 Company Tracking Number:
 TOI: *LTC03I Individual Long Term Care* Sub-TOI: *LTC03I.003 Other*
 Product Name: *LTC FORMS*
 Project Name/Number: *LTC FORMS/LTC FORMS*

Form Schedule

Lead Form Number: A-LTC-RFAR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	A-LTC-RFAR	Application/ Enrollment Form	APPLICATION	Other	Other Explanation: Informational Filing	40.000	A-LTC-RF-AR.pdf
	PM1993	Other	PERSONAL WORKSHEET	Other	Other Explanation: Informational filing		PM1993.pdf

**PHYSICIANS MUTUAL INSURANCE COMPANY
 PHYSICIANS LIFE INSURANCE COMPANY
 LONG-TERM CARE POLICY APPLICATION
 2600 Dodge Street Omaha, Nebraska 68131**

(Home Office Use Only) Franchise/List Bill # _____)

APPLICANT INFORMATION - PLEASE PRINT

EMPLOYER/ASSOC. NAME AND NUMBER (If Applicable)	<input type="checkbox"/> Employee: date of hire _____ <input type="checkbox"/> Employee's spouse <input type="checkbox"/> Family member: Relationship _____ (Employee/Member Name: _____)
--	--

PERSONAL INFORMATION (Please note each box must be marked Individually)

Applicant's Name _____
(Please Print) (First) (Middle Initial) (Last)

Street Address _____
(Apt. No.)

City _____ State _____ Zip Code _____ SS# _____ / _____ / _____

Birthdate _____ Age _____ Height _____ Weight _____ Sex _____
(Month) (Day) (Year) (Ft/In) (Lbs)

Applicant's Telephone No.	Best time to call	E-mail address (Optional)
Area Code _____	<input type="checkbox"/> _____ A.M. <input type="checkbox"/> _____ P.M.	

Beneficiary	Applicant Status
Name: _____ Relationship: _____ Address: _____	<input type="checkbox"/> Single <input type="checkbox"/> Married, Spouse <u>NOT</u> Applying <input type="checkbox"/> Married, Spouse currently has a Physicians Mutual Long-Term Care Policy or is applying today. Spouse's Name: _____

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Are you a U.S. citizen?
<input type="checkbox"/>	<input type="checkbox"/>	If no, have you resided in the United States for more than 2 years and are you a permanent resident? (If yes, please provide a copy of your green card.)

<input type="checkbox"/>	<input type="checkbox"/>	1. Are you covered by Medicaid (not Medicare)?
<input type="checkbox"/>	<input type="checkbox"/>	2. A. Do you have another Long-Term Care Insurance Policy or certificate in force (including health care service contract, health maintenance organization contract); or do you have an Application pending for that type of coverage with this or any other company? If so, with which company? _____ Daily Benefit: \$ _____ Type of coverage <input type="checkbox"/> Comprehensive <input type="checkbox"/> Facility Care <input type="checkbox"/> Home & Community Care <input type="checkbox"/> Other _____ B. If you currently have Long-Term Care coverage with Us, please list Policy Number: _____
<input type="checkbox"/>	<input type="checkbox"/>	3. Did you have another Long-Term Care Insurance Policy or certificate in force during the past 12 months? If so, with which company? _____ If that Policy lapsed, when did it lapse? ____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you intend to replace any of your Long-Term Care, medical, or health insurance coverage with this Policy? If so, please list name and address of insurer being replaced: _____
<input type="checkbox"/>	<input type="checkbox"/>	5. Within the past three years have you: Been declined, postponed, restricted, rated, or charged an extra premium for disability, long term care, or health insurance? If yes, explain why: _____

SECTION C

PERSONAL PROFILE

YES NO

- 1. Do you drive at least 1,500 miles per year?
Driver's License # _____ State _____ Expiration Date _____
- 2. In the last 6 MONTHS have you actively worked? If Yes, how many hours per week? Describe your occupation and duties? _____

If retired, date of retirement: _____
- 3. If you have actively worked during the last 6 MONTHS, have you missed more than five consecutive days of work due to accidents, injury, sickness, or any physical or cognitive impairment? If Yes, please describe: _____
- 4. During the last 12 months, have you ever required assistance or supervision of any kind to perform any everyday activity, such as mobility (including the use of pronged canes), taking medications, dressing, eating, walking, bathing, transferring, or toileting? Please **circle** any that apply. Please explain. _____
- 5. Do you currently do volunteer work or participate in outside activities on a regular basis? If Yes, please describe: _____
- 6. Are you receiving disability income, workers' compensation or any state or Social Security Disability Benefits?
If YES, please give details: _____
- 7. Do you use a Quad Cane, Hospital Bed, or any other mechanical device? Do you need assistance with: Shopping; Walking; Using Transportation; Housekeeping or Cooking? Please **circle** any that apply. Please explain: _____
- 8. With whom do you live? Alone Spouse Other Family (relationship) _____
How long have you lived together? _____

SECTION D

Protection Against Unintended Lapse

I understand that I have the right to designate at least one person other than myself to receive notice of cancellation of this Long-Term Care insurance policy for non-payment of premium. I understand that the notice to my designee will not be given until 30 days after a premium is due and unpaid. I understand that I may elect NOT to designate any person to receive such notice.

- I elect NOT to designate any person to receive such notice.**
- Please notify the following person in the event my policy premium is not paid within 30 days of any premium due date.**

NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE: _____

The designate is not responsible for payment of the premium for unintended lapse.

SECTION E

Disclosure

The information provided here is not intended as legal or tax advice. Clients are advised to consult with their own attorney, accountant or tax advisor regarding the tax implications of purchasing Long Term-Care insurance.

The Health Insurance Portability and Accountability Act of 1996, also known as the "Kennedy-Kassebaum Act" amended the Internal Revenue Code to provide federal income tax advantages for long term care insurance policies that meet certain requirements. Policies that meet these requirements are called QUALIFIED Long-Term Care Insurance policies. Subject to limitations under the law, certain premium payments for QUALIFIED policies are tax deductible and long term care benefits received under these policies will be treated as non-taxable income.

I understand and acknowledge that A QUALIFIED LONG-TERM CARE INSURANCE POLICY AS DEFINED UNDER SECTION 7702B OF THE INTERNAL REVENUE CODE WILL BE ELIGIBLE FOR CERTAIN TAX ADVANTAGES. I also understand that A NON-QUALIFIED LONG-TERM CARE POLICY MAY NOT BE ELIGIBLE FOR THESE TAX ADVANTAGES.

I am applying for a QUALIFIED _____ NON-QUALIFIED _____ Long-Term Care Policy.

SECTION F

AGREEMENT:

I agree that: (1) the answers contained herein are full, complete and true to the best of my knowledge and belief; (2) this application will be a part of the contract of insurance under which I am applying; and (3) the insurance will become valid and effective only if: (a) this application is approved by the Company; (b) a policy is issued during my lifetime; (c) the first premium has been paid; and (d) until the effective date set by the Company, I remain at a level of health that qualifies me for the insurance as determined by the Company. If approved, the effective date will be stated in the policy issued to me.

RECEIPT:

I received the following when I applied for insurance under this policy with Physicians Mutual Insurance Company:

- 1. **Outline of Coverage**
- 2. **(If eligible for Medicare) "Guide to Health Insurance for People with Medicare"**
- 3. **"A Shopper's Guide to Long-Term Care Insurance"**

I have reviewed the Shortened Benefit Period Non-Forfeiture Rider and I accept or decline.

I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of the Policy with or without inflation protection. I realize that, based on current health care cost trends, the benefits provided by a Long-Term Care plan which does not have meaningful inflation protection may be significantly diminished in terms of real value, depending on the amount of time which elapses between the date I purchase the policy and the date on which I first become eligible for benefits. Specifically, I have reviewed the option for the Compound Inflation Protection Benefit Plan(s) _____, and I reject this inflation protection.

Caution: If your answers on this application are incorrect or untrue, Physicians Mutual Insurance Company may have the right to deny benefits or rescind your policy.

No agent may: change, waive, or alter the terms and conditions of this application; accept risks; guarantee insurability; make or modify contracts or waive any of the Company's rights or requirements.

Any person who knowingly presents a false or fraudulent claim for payment for 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.

Date Application Completed: _____ Dated At: _____
Month Day Year City State

Signature of Applicant – Owner _____

Licensed and Appointed Agent _____

Agent License # _____

A-LTC-RFAR

Do Not Write Below This Line
HOME OFFICE USE ONLY

Policy Kind	Submitted Premium	Region	Division	Repl
Split %	Agent 1	Profile	NPN	
Split %	Agent 2	Profile	NPN	
Split %	Agent 3	Profile	NPN	
Split %	Agent 4	Profile	NPN	

AUTOMATIC BANK-WITHDRAW AUTHORIZATION

Pay Your Premiums The Easy Way With The Automatic Bank-Withdraw Plan

AUTHORIZATION TO WITHDRAW FUNDS BY PHYSICIANS MUTUAL INSURANCE COMPANY, OMAHA, NEBRASKA. As a convenience to me, I authorize you to make payments to Physicians Mutual Insurance Company, Omaha, NE, by withdrawing funds from my account by check, draft or automatic debit entry. I agree that your rights with respect to each such charge will be the same as if it were personally executed by me. The payment of premiums by this method may be discontinued by the Company or myself upon 30 days written notice. This authorization is to remain in effect until you receive notice from me to revoke it.

DEPOSITORY NAME	ACCOUNT NUMBER (Attach a voided check)	
CITY STATE	ZIP	<input type="checkbox"/> Checking
SIGNATURE (As it appears on bank records)	DATE	<input type="checkbox"/> Savings
SPOUSE'S SIGNATURE (If joint account)		

(ATTACH VOIDED CHECK HERE)

LONG TERM CARE INSURANCE PERSONAL WORKSHEET

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for Long-Term Care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care, or don't want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be \$ _____ per month, or \$ _____ per year.

Type of Policy (guaranteed renewable): _____

The Company's Right to Increase Premiums: We may change your renewal premium only if we make the same change for all policies of this form and class in the state where you live.

Rate Increase History

The company has a right to increase premiums in the future. The company has sold long-term care insurance since 1988 and has sold this policy since 2004. The company has raised its rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.

Policy Form	Years Available for Sale	Rate History
P122, P123 and P522	1988-1994	No rate increase
P124, P125, P126, P127, P130, P131, P103, P104, P106 and P107	1994-2007	2009 – 19%
P141 and P641	1997 – 2003	No rate increase
P105, P108 and P109	2001 – 2005	No rate increase
P145, P146, P147 and P148	2004 – Present	No rate increase

Questions Related to Your Income

How will you pay each year's premiums?

From my Income From my Savings/Investments My Family will Pay

Have you considered whether you could afford to keep this policy if the premium went up, for example, by 20%?

What is your annual income? (check one)

Under \$10,000 \$10-20,000 \$20-30,000 \$30-50,000 Over \$50,000

How do you expect your income to change over the next 10 years? (check one)

No Change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

From my Income From my Savings/Investments My Family will Pay

The national average annual cost of care in 2004 was \$61,700, but this figure varies across the country. In ten years the national average annual cost would be about \$100,550, if costs increase 5% annually.

What elimination period are you considering? Number of days _____ Approximate cost \$ _____
for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

From my Income From my Savings/Investments My family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

Under \$20,000 \$20,000-30,000 \$30,000-50,000 Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

The answers to the questions above (check one) I choose not to complete this information.
describe my financial situation.

I acknowledge that the carrier and/or its Insurance Producer (below) has reviewed this form with me, including the premium, premium rate increase history, and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked)

Signed: _____
(Applicant) (Date)

I explained to the applicant the importance of completing this information.

Signed: _____
(Insurance Producer) (Date)

Insurance Producer's Printed Name: _____

My Insurance Producer has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.

Signed: _____ Date _____

The company may contact you to verify your answers.

SERFF Tracking Number: *PHYS-126441735* State: *Arkansas*
 Filing Company: *Physicians Mutual Insurance Company* State Tracking Number: *44476*
 Company Tracking Number:
 TOI: *LTC03I Individual Long Term Care* Sub-TOI: *LTC03I.003 Other*
 Product Name: *LTC FORMS*
 Project Name/Number: *LTC FORMS/LTC FORMS*

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachments:		
Ar reg 19 cert.pdf		
READCERT Standard.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments:		
See Forms Tab		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification		
Bypass Reason: This is an informational only filing of an application and personal worksheet.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage		
Bypass Reason: This is an informational only filing of an application and personal worksheet.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: LTC Partnership Certification		
Bypass Reason: This is an informational only filing of an application and personal worksheet.		
Comments:		

CERTIFICATION

RE: A-LTC-RFAR, PM1993

This is to certify that the above captioned filing complies with Arkansas Regulation 19 and all other applicable requirements of the Arkansas Insurance Department.

A handwritten signature in black ink that reads "Shawn Pollock". The signature is written in a cursive style. To the right of the signature, there is a vertical red line.

Date: January 5, 2010

Shawn Pollock
Vice President
Government and Industry

PHYSICIANS MUTUAL INSURANCE COMPANY

OMAHA, NEBRASKA

Certification of Flesch

These form(s) have the following Flesch Readability Score:

<u>Form</u>	Flesch	<u>Score</u>
A-LTC-RFAR		40*

*When scored with base policy, score will always be greater than minimum required by law.



Vice President
Physicians Mutual Insurance Company

January 5, 2010
Date