

SERFF Tracking Number: PHYS-126441787 State: Arkansas
Filing Company: Physicians Mutual Insurance Company State Tracking Number: 44480
Company Tracking Number:
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
Product Name: A2010T-AR
Project Name/Number: A2010T-AR/A2010T-AR

Filing at a Glance

Company: Physicians Mutual Insurance Company

Product Name: A2010T-AR

SERFF Tr Num: PHYS-126441787 State: Arkansas

TOI: MS09 Medicare Supplement - Other 2010 SERFF Status: Closed-Approved-
Closed State Tr Num: 44480

Sub-TOI: MS09.000 Medicare Supplement
Other 2010

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Stephanie Fowler

Author: Kathryn Gurnett

Disposition Date: 01/27/2010

Date Submitted: 01/05/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: A2010T-AR

Status of Filing in Domicile: Not Filed

Project Number: A2010T-AR

Date Approved in Domicile:

Requested Filing Mode:

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: 01/27/2010

Explanation for Other Group Market Type:

State Status Changed: 01/27/2010

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 Medicare Supplement

A2010T-AR Application

Informational Filing

The above captioned form is being sent to you for informational purposes and replaces the A2010T-AR which was previously approved by your department on August 13, 2009.

SERFF Tracking Number: *PHYS-126441787* State: *Arkansas*
Filing Company: *Physicians Mutual Insurance Company* State Tracking Number: *44480*
Company Tracking Number:
TOI: *MS09 Medicare Supplement - Other 2010* Sub-TOI: *MS09.000 Medicare Supplement Other 2010*
Product Name: *A2010T-AR*
Project Name/Number: *A2010T-AR/A2010T-AR*

The only revision to this form is changing the word "Agent" to "Producer" so it would coincide with our advertising. No other changes were made to this form.

We reserve the right to alter the format of the form submitted without re-filing due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to wording or content would be filed for prior approval.

Please contact me via SERFF, or at the e-mail address or phone number listed below if you have questions, or if additional information is needed.

Sincerely,

Kathryn R. Gurnett, MBA, CPCU, CLU, HIA, AAPA, LTCP, HIPAAP, AIRC, FLMI, CCP
Compliance Lead
Government and Industry
Voice: (402) 633-1188
Fax: (402) 633-1096
E-mail: katie.gurnett@physiciansmutual.com

Company and Contact

Filing Contact Information

Kathryn Gurnett, Policy Approval & Compliance katie.gurnett@physiciansmutual.com
Coordinator
2600 Dodge Street 402-633-1188 [Phone]
Omaha, NE 68131 402-633-1096 [FAX]

Filing Company Information

Physicians Mutual Insurance Company	CoCode: 80578	State of Domicile: Nebraska
2600 Dodge Street	Group Code: 367	Company Type:
Omaha, NE 68131	Group Name:	State ID Number:
(402) 633-1188 ext. [Phone]	FEIN Number: 47-0270450	

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Physicians Mutual Insurance Company	\$50.00	01/05/2010	33263802

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	01/27/2010	01/27/2010

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Disposition

Disposition Date: 01/27/2010

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	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	application	Approved	Yes

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Form Schedule

Lead Form Number: A2010T-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/27/2010	A2010T-AR	Application/ Enrollment Form	application	Other	Other Explanation: Informational Filing	53.600	A2010T- AR.pdf

**Medicare Supplement Application to
PHYSICIANS MUTUAL INSURANCE COMPANY®
2600 Dodge Street • Omaha, Nebraska 68131**

Policy No. _____

Source I.D. _____

Please print the following information.

Applicant's Name _____ Date of Birth _____
First Middle Initial Last Mo. Day Yr.

Street _____ Apt. _____ Age _____ Sex _____
 Address _____

City _____ State _____ Zip _____ Phone No. (____) _____
Area Code

E-mail address (optional) _____

Applicant's Medicare Health Insurance Claim Number (HICN) _____
(exactly as shown on your Medicare card)

Annual Quarterly Semi-annual Monthly ABW TYPE 1

_____/_____/_____ ____/____/_____ \$ _____ \$ _____
 Date of Application Effective Date Premium Collected Modal Premium

Plan Selection: *(Check One)*

Rate Structure: *(Check One)*

<input type="checkbox"/> Plan A / _{P020} <input type="checkbox"/> Plan F / _{P025} <input type="checkbox"/> High Deductible Plan F / _{P027} <input type="checkbox"/> Plan G / _{P026}	<input type="checkbox"/> Community Rating ₍₁₀₎
<input type="checkbox"/> Plan F / _{P025} With Innovative Discount Rider / _{B345}	<input type="checkbox"/> Community Rating ₍₂₀₎

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for Guaranteed Issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

To the best of your knowledge:	YES	NO
1. Are you enrolled in Part A and Part B of Medicare?	<input type="checkbox"/>	<input type="checkbox"/>
2. Did you turn age 65 in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
Have you enrolled in Medicare Part B for the first time in the last six months?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, you do NOT need to answer questions 7-21. If yes, please show date of enrollment (month/day/year) ____/____/____		
3. Are you covered for medical assistance through the state Medicaid program?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
4. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. Start ___ / ___ / ___ End ___ / ___ / ___		
a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please show requested date of termination/disenrollment ___ / ___ / ___		
b. Was this your first time in this type of Medicare plan?	<input type="checkbox"/>	<input type="checkbox"/>
c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
5. Do you have another Medicare Supplement policy in force?	<input type="checkbox"/>	<input type="checkbox"/>
a. If so, with what company and what plan do you have? _____ _____		
b. If so, do you intend to replace your current Medicare Supplement policy with this policy? ..	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please show requested date of termination/disenrollment ___ / ___ / ___		

	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)	<input type="checkbox"/>	<input type="checkbox"/>
a. If so, 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 ___ / ___ / ___		
c. If you are still covered by the policy described above, do you intend to replace your current coverage with this new Medicare Supplement policy?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please show requested date of termination/disenrollment ___ / ___ / ___		

	YES	NO
7. Have you been hospitalized or confined to a nursing home within the past 90 days, or have you been hospitalized 2 or more times in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you require the use of a walker?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you bedridden, or do you require the use of a wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have or have you been told by a medical professional that you have Alzheimer's Disease, Dementia, or any other cognitive disorder?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you been diagnosed as having, or received treatment by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), and/or Positive HIV and/or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you taking prescription drugs for both diabetes and a heart condition (including high blood pressure)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you taking anti-coagulant (blood thinner) drugs?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you been advised by a medical professional that you may need surgery or a non-routine medical procedure within the next 12 months? (includes cataract surgery)	<input type="checkbox"/>	<input type="checkbox"/>

YES NO

15. Within the past 2 years have you been diagnosed with, told by a medical professional that you have, or have you been treated for any of the following:

- alcoholism; drug addiction (or drug abuse)
- internal cancer; leukemia; malignant melanoma;
- congestive heart failure; valvular heart disease; coronary artery disease; heart rhythm disorder; heart attack; heart surgery (includes bypass, balloon surgery, or placement of an arterial stent);
- insulin dependent diabetes;
- systemic lupus erythematosus (SLE);
- multiple sclerosis; Amyotrophic Lateral Sclerosis (ALS); Parkinson’s Disease;
- fractures or amputation caused by disease; degenerative bone disease; severe arthritis involving major joints (hip, knee or shoulder) or the spine;
- liver disease; chronic kidney disorder; kidney failure; kidney dialysis;
- chronic obstructive pulmonary disease (COPD) or emphysema;
- an illness or condition for which you use oxygen;
- stroke; transient ischemic attack (TIA);

Note: If you answered “YES” to any of questions 7-15, you will not qualify for coverage.

16. Please provide your height _____ and weight _____.

17. Have you used tobacco products in the past 12 months?

18. Do you have a Chronic Lung Disease, Chronic Bronchitis, or Breathing Disorder?

19. In the past 12 months have you received medical treatment in an assisted living facility?
If yes, please explain

20. Do you have a mental disease or disorder requiring medication (including depression)?

21. In the past 12 months, have you taken or been advised to take any prescription drugs, over the counter drugs, or medicines including narcotics, barbiturates or amphetamines?
If “YES,” indicate the specifics below:

Medication Name	Quantity Taken	Dosage	Prescribing Physician	Illness for Which Medication Prescribed	Date Last Prescribed

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- (1) You do not need more than one Medicare Supplement 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 policy.
- (4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement 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 the 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 Medicare Supplement insurance 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).

The Undersigned applicant and insurance producer certify that the applicant has read, or had read to him or her, 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.

I represent and agree that all information stated in this application is complete and correct to the best of my knowledge.

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.

Signature of Applicant _____

Date Application Completed _____ Dated at _____
Mo. Day Yr City State

I represent and agree that I have truly and accurately recorded in this application all information supplied by the applicant and personally witnessed (his-her) signature.

This policy does replace does not replace any insurance presently in force.

Signature of Licensed Resident Insurance
Producer(s)

Signature of Licensed Resident Insurance
Producer(s)

Print Name of Licensed Resident Insurance
Producer(s)

Print Name of Licensed Resident Insurance
Producer(s)

NPN of Licensed Resident Insurance Producer(s)

NPN of Licensed Resident Insurance Producer(s)

TO BE FILLED OUT BY INSURANCE PRODUCER

1. List any other health insurance policies you have sold the applicant which are still in force:

2. List any other health insurance policies you have sold the applicant in the past five (5) years which are no longer in force:

A2010T-AR

ACKNOWLEDGMENT

The renewal provision of the policy for which I am applying this date has been explained to me. I understand the policy cannot be cancelled by the Company except when I do not pay my premium when due or within the 31 day grace period. The Company may change the premium only if the same change is made for all policies of the same form and class held by residents of my state. I further acknowledge receipt of the Outline of Coverage, the Guide to Health Insurance for People with Medicare, and the Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage and all other forms unique to my State of residence. I understand I may be interviewed by telephone to verify the application information.

Date _____ Signature of Applicant **X** _____

ADDITIONAL INFORMATION REGARDING CURRENT OR PENDING COVERAGE

Does anyone proposed for coverage have other health or life insurance coverage with Physicians Mutual or Physicians Life Insurance Company currently pending or issued within the last 90 days? If Yes, please provide the following information:

Name: _____

Policy Kind(s) (LTC, Specified Disease, etc): _____

Policy Number(s): _____

Date Issued (if applicable): _____

THIRD PARTY DESIGNEE

I understand that I can designate one person other than myself to be notified in the event of an unintentional lapse of my Medicare Supplement Insurance Policy. I understand that the notice to my designee will not be given until 15 days after my 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 15 days of any premium due date.

NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE: _____

POLICYOWNER PROXY (for Physicians Mutual Insurance Company)

I hereby appoint the Board of Directors of Physicians Mutual Insurance Company, or a majority of such of them as actually are present, as my proxy with full power and authority to vote and otherwise act for me in my behalf at all annual and special meetings of the policyholders at which I am not present, and I also direct that this proxy shall not expire but shall continue in force until withdrawn by me by written notice mailed to the Company.

X _____

Policyholder Signature Here

Date

BUSINESS OWNER WAIVER

As the owner of _____, I understand that this individual health insurance policy(s) is not and will not be considered a group health plan according to the Employee Retirement Income Security Act (ERISA); therefore, the premium being paid by the business account will not be used as a business expense. I understand that I should contact my tax advisor about the deductions of health insurance premiums.

X _____

Signature of Business Owner (in ink)

Date

PM-1902A

Rev. 11/06

INSURANCE PRODUCER'S REPORT

Are you related to any Proposed Insured by blood or marriage? Yes No

What is your relationship? _____

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	01/27/2010

Comments:

Attachments:

Ar reg 19 cert.pdf
 READCERT Standard.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	01/27/2010

Comments:

Please see Forms tab.

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

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

CERTIFICATION

RE: A2010T-AR

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 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>	<u>Flesch Score</u>
A2010T-AR	53.6



Vice President
Physicians Mutual Insurance Company

January 5, 2010
Date