

SERFF Tracking Number: IASL-126823909 State: Arkansas
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 46879
 Company Tracking Number: HNMSAA2010AR
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
 Standard Plans 2010
 Product Name: HN AR 2010 Forms
 Project Name/Number: HN AR 2010 Forms/

Filing at a Glance

Company: Heartland National Life Insurance Company

Product Name: HN AR 2010 Forms SERFF Tr Num: IASL-126823909 State: Arkansas
 TOI: MS08I Individual Medicare Supplement - Standard Plans 2010 SERFF Status: Closed-Approved-Closed State Tr Num: 46879
 Sub-TOI: MS08I.001 Plan A 2010 Co Tr Num: HNMSAA2010AR State Status: Approved-Closed
 Filing Type: Form/Rate Reviewer(s): Stephanie Fowler
 Author: Beth Clark Disposition Date: 10/14/2010
 Date Submitted: 09/23/2010 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date: 10/14/2010

State Filing Description:

General Information

Project Name: HN AR 2010 Forms Status of Filing in Domicile: Pending
 Project Number: 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: 10/14/2010 Explanation for Other Group Market Type:
 State Status Changed: 10/14/2010
 Deemer Date: Created By: Beth Clark
 Submitted By: Beth Clark Corresponding Filing Tracking Number:

Filing Description:

This is a new form filing for Medicare Supplement 2010 Plans. These forms are being filed in compliance with the requirements of the Federal Medicare Improvements for Patients and Providers Act (MIPPA) as well as your state's Medicare Supplement Regulation.

Ancillary forms include the application, amendment to application, reinstatement application, a replacement notice and the outline of coverage.

The Amendment to Application will be used when applicant leaves an answer blank or changes are made to the

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application without the applicant's initials. The form will be sent to the applicant for their signature. For your information, we are enclosing the variable language for the amendment to application.

Heartland National Life Insurance Company intends to market Plans A, D, F, G, M and N. These policies will be sold to individuals through independent agents and issued to persons eligible for Medicare.

Company and Contact

Filing Contact Information

Beth Clark, Compliance Analyst beth.clark@iasadmin.com
 8545 126th Avenue North 727-584-0007 [Phone] 2169 [Ext]
 Suite 200 727-584-5613 [FAX]
 Largo, FL 33773-1502

Filing Company Information

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

Heartland National Life Insurance Company	CoCode: 66214	State of Domicile: Indiana
10689 N. Pennsylvania Street	Group Code:	Company Type: Life and Health Insurer
Indianapolis, IN 46280	Group Name:	State ID Number:
(816) 478-0120 ext. [Phone]	FEIN Number: 64-0431935	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$550.00
Retaliatory?	No
Fee Explanation:	\$50/Form x 11 Forms
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Heartland National Life Insurance Company	\$550.00	09/23/2010	39809216

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	10/14/2010	10/14/2010
Approved-Closed	Stephanie Fowler	10/14/2010	10/14/2010

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	10/13/2010	10/13/2010	Beth Clark	10/14/2010	10/14/2010

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Disposition

Disposition Date: 10/14/2010

Implementation Date: 10/14/2010

Status: Approved-Closed

Comment: This approval is subject to the following:

- Increases will not be given more frequently than once in a twelve-month period;
- Both the insured and agent shall be notified by the insurer of its intention to increase the rate for renewal not less than thirty (30) days prior to the effective date of the renewal.

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	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Letter of Authorizat	Accepted for Informational Purposes	Yes
Supporting Document	Explanation of Variability for Amendment to Application	Approved	Yes
Form	Medicare Supplement Plan A	Approved	Yes
Form	Medicare Supplement Plan D	Approved	Yes
Form	Medicare Supplement Plan F	Approved	Yes
Form	Medicare Supplement Plan G	Approved	Yes
Form	Medicare Supplement Plan M	Approved	Yes
Form	Medicare Supplement Plan N	Approved	Yes
Form (revised)	Medicare Supplement Application	Approved	Yes
Form	Medicare Supplement Application	Disapproved	Yes
Form	Medicare Supplement Outline of Coverage	Approved	Yes
Form	Medicare Supplement Reinstatement Application	Approved	Yes
Form	Medicare Supplement Replacement Notice	Approved	Yes
Form	Amendment to Application	Approved	Yes
Rate	Rate Sheets	Approved	Yes

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Supporting Document	Explanation of Variability for Amendment to Application	Approved	Yes
Form	Medicare Supplement Plan A	Approved	Yes
Form	Medicare Supplement Plan D	Approved	Yes
Form	Medicare Supplement Plan F	Approved	Yes
Form	Medicare Supplement Plan G	Approved	Yes
Form	Medicare Supplement Plan M	Approved	Yes
Form	Medicare Supplement Plan N	Approved	Yes
Form (revised)	Medicare Supplement Application	Approved	Yes
Form	Medicare Supplement Application	Disapproved	Yes
Form	Medicare Supplement Outline of Coverage	Approved	Yes
Form	Medicare Supplement Reinstatement Application	Approved	Yes
Form	Medicare Supplement Replacement Notice	Approved	Yes
Form	Amendment to Application	Approved	Yes
Rate	Rate Sheets	Approved	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 10/13/2010
Submitted Date 10/13/2010
Respond By Date 11/15/2010

Dear Beth Clark,

This will acknowledge receipt of the captioned filing.

Objection 1

- Medicare Supplement Application, HNAPP2010AR (Form)

Comment: R&R 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to the Health Question section since it is not required to be answered during Open Enrollment.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 10/14/2010
 Submitted Date 10/14/2010

Dear Stephanie Fowler,

Comments:

Good Afternoon,

Response 1

Comments: The tobacco question has been moved to the health questions and we have added a disclosure that the questions will not require an answer if applicant is applying during open enrollment or guarantee issue.

Related Objection 1

Applies To:

- Medicare Supplement Application, HNAPP2010AR (Form)

Comment:

R&R 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to the Health Question section since it is not required to be answered during Open Enrollment.

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 Application	HNAPP2010AR		Application/Enrollment Form	Initial			HNAPP2010AR.pdf
Previous Version							
Medicare Supplement	HNAPP20		Application/Enrollment	Initial			HNAPP20

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Application 10AR Form 10AR.pdf

No Rate/Rule Schedule items changed.

Thank you for your time and attention to the review of this filing.

Sincerely,
Beth Clark

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Form Schedule

Lead Form Number: HNMSAA2010AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 10/14/2010	HNMSAA2 010AR	Policy/Cont	Medicare ract/Fratern Supplement Plan A al Certificate	Initial		50.000	HNMSAI2010 AR.pdf
Approved 10/14/2010	HNMSDA2 010AR	Policy/Cont	Medicare ract/Fratern Supplement Plan D al Certificate	Initial		50.000	HNMSDI2010 AR.pdf
Approved 10/14/2010	HNMSFA2 010AR	Policy/Cont	Medicare ract/Fratern Supplement Plan F al Certificate	Initial		50.200	HNMSFI2010 AR.pdf
Approved 10/14/2010	HNMSGA2 010AR	Policy/Cont	Medicare ract/Fratern Supplement Plan G al Certificate	Initial		50.200	HNMSGI2010 AR.pdf
Approved 10/14/2010	HNMSMA2 010AR	Policy/Cont	Medicare ract/Fratern Supplement Plan M al Certificate	Initial		50.500	HNMSMI2010 AR.pdf
Approved 10/14/2010	HNMSNA2 010AR	Policy/Cont	Medicare ract/Fratern Supplement Plan N al Certificate	Initial		51.100	HNMSNI2010 AR.pdf
Approved 10/14/2010	HNAPP201 0AR	Application/	Medicare Enrollment Supplement Form Application	Initial			HNAPP2010A R.pdf
Approved 10/14/2010	HNOC2010 AR	Outline of	Medicare Coverage Supplement Outline of Coverage	Initial			HNOC2010A R.pdf

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Approved	HNREST20	Application/Medicare	Initial	HNREST2010
10/14/2010	10GN	Enrollment Supplement		GN.pdf
		Form Reinstatement		
		Application		
Approved	MSREPL20	Other Medicare	Initial	MSREPL2010
10/14/2010	10	Supplement		.pdf
		Replacement Notice		
Approved	HN-ATA	Other Amendment to	Initial	HN-ATA.pdf
10/14/2010		Application		

**HEARTLAND NATIONAL LIFE INSURANCE COMPANY.
[Indianapolis, Indiana 46280]**

MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN A

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US

READ YOUR POLICY CAREFULLY

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We," "Our" and "Us" means Heartland National Life Insurance Company

NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

IMPORTANT NOTICE: Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Medicare Supplement Administrative Office at:

**[P.O. Box 10814]
Clearwater, Florida 33757-8814]
[877-431-7371]**

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at 12:01 A.M. Standard Time, at the place where You reside, on the Policy Effective Date shown on the Policy Schedule. It ends at 12:00 o'clock midnight, Standard Time, at the place where You reside, on the day before Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule.

THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

GUARANTEED RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state and zip code of residence. Any change in Premium will occur on your Policy Anniversary Date. Your Policy Anniversary Date is the same month and day as the Policy Effective Date for each succeeding year this Policy remains in force. We will give You the advance written notice required by Your state prior to any premium change.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION

THIS IS A NON-PARTICIPATING POLICY

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APPLICATION Attached

POLICYHOLDER INFORMATION

For support and information regarding policy terms, premium payments, claims processing and payment, contact us at:

Medicare Supplement Administration
[P. O. Box 10814]
[Clearwater, Florida 33757-8814]
[1-877-431-7371]

For your information, the following is the name, address and telephone number of your agent:

The Arkansas Insurance Department can be contacted at:

Arkansas Insurance Department
Consumer Services
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-501-371-2640

Toll Free Consumer Information Telephone Number
1-800-852-5494

POLICY SCHEDULE

INSURED:

POLICY EFFECTIVE DATE:

POLICY NUMBER:

ISSUE AGE:

STATE OF ISSUE:

MODE AT ISSUE:

MODAL PREMIUM:

PREMIUM TERM:

UNDERWRITING CLASS:

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN A

DEFINITIONS

Benefit Period means the period as determined by Medicare which begins on the date, You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

Hospital means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or Hospitalization means being confined in a Hospital on an inpatient basis.

Immediate Family means Your spouse; parents; grandparents; children; or siblings, and their spouses.

Injury means a bodily injury which is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

Medicaid means the medical assistance program under Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

Policy Effective Date means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

Sickness means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

The benefits paid under this Policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61st) day through the ninetieth (90th) day in any Medicare Benefit Period.

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider will accept Our payment as payment in full and may not bill You for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital Confinement, subject to the Medicare Part B deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare Eligible Expenses for hospice care and respite care expenses.

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare deductibles, copayment or coinsurance amounts. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the PREMIUMS SUBJECT TO CHANGE provision on page 1.

MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of Your coverage provides for:

1. No waiting period with respect to treatment of preexisting conditions.
2. Coverage equivalent to coverage in effect before the date of suspension; and
3. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

EXTENSION OF BENEFITS

Upon termination of this Policy, an extension of benefits will be granted for any continuous loss which commenced during a period where the Policy was in force and the premium was paid. This extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

EXCLUSIONS

We will not pay benefits for:

- (a) Expenses incurred while this policy is not in force except as provided in the Extension of Benefits section;
- (b) Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
- (c) That portion of any expense incurred which is paid for by Medicare;
- (d) Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions;
- (e) Services for which a charge is not normally made in the absence of insurance; or
- (f) Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, including the endorsements and attached documents if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After three (3) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the three (3) year period.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of each premium due after the initial premium. The Policy will remain in force during the grace period. If the premium is not paid during the grace period, coverage will terminate as of the date the premium was due and claims incurred on or after that date will not be considered for payment. A grace period does not apply if You cancel Your Policy.

REINSTATEMENT: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from Injury or Sickness as may begin on or after the date of reinstatement. In all other respects the Company and the Insured shall have the same rights under the Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Heartland National Life Insurance Company, Medicare Supplement Claims Processing Center, [P.O. Box 10813 Clearwater, Florida 33757-8813.]

CLAIM FORMS: When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

PROOF OF LOSS: We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

We shall pay interest to You equal to twelve percent (12%) per annum on the proceeds or benefits due under the terms of this Policy for failure to comply with the requirements of this provision.

GENERAL POLICY PROVISIONS CONTINUED

ELECTRONIC CLAIM FILING PROCESS: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and Hospital expenses You incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and then passes Your claim electronically to Us for consideration of benefits under Your Medicare Supplement Policy. We will accept Medicare's electronic submission of Your claim to Us as Your notice of claim. For consideration of expenses that are not submitted electronically to Us Your Medicare Summary Notice or Medicare Benefit Notice can serve as Your notice of claim. This Medicare statement shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare statement to Us or Your health care provider may submit it to Us on Your behalf.

PHYSICAL EXAMINATIONS: At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE LAWS: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Heartland National Life Insurance Company, Medicare Supplement Claims Processing Center, [P.O. Box 10813 Clearwater, Florida 33757-8813.]

CLERICAL ERROR: Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

MISSTATEMENT OF AGE: If Your age has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

PRO RATA REFUND: If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

CANCELLATION BY INSURED: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation except as provided for under the Extension of Benefits provision.

This Policy is signed for Heartland National Life Insurance Company by its President and Secretary.

[SIGNATURE]

[PRESIDENT]

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
Home Office: [Indianapolis, Indiana 46280]

MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN D

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US

READ YOUR POLICY CAREFULLY

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We," "Our" and "Us" means Heartland National Life Insurance Company.

NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

IMPORTANT NOTICE: Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Medicare Supplement Administrative Office at:

[P.O. Box 10814]
[Clearwater, Florida 33757-8814]
[877-431-7371]

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at 12:01 A.M. Standard Time, at the place where You reside, on the Policy Effective Date shown on the Policy Schedule. It ends at 12:00 o'clock midnight, Standard Time, at the place where You reside, on the day before Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule.

THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

GUARANTEED RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state and zip code of residence. Any change in Premium will occur on your Policy Anniversary Date. Your Policy Anniversary Date is the same month and day as the Policy Effective Date for each succeeding year this Policy remains in force. We will give You the advance written notice required by Your state prior to any premium change.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION

THIS IS A NON-PARTICIPATING POLICY

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POLICYHOLDER INFORMATION

For support and information regarding policy terms, premium payments, claims processing and payment, contact us at:

Medicare Supplement Administration
[P. O. Box 10814]
[Clearwater, Florida 33757-8814]
[1-877-431-7371]

For your information, the following is the name, address and telephone number of your agent:

The Arkansas Insurance Department can be contacted at:

Arkansas Insurance Department
Consumer Services
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-501-371-2640

Toll Free Consumer Information Telephone Number
1-800-852-5494

POLICY SCHEDULE

INSURED:

POLICY EFFECTIVE DATE:

POLICY NUMBER:

ISSUE AGE:

STATE OF ISSUE:

MODE AT ISSUE:

MODAL PREMIUM:

PREMIUM TERM:

UNDERWRITING CLASS:

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN D

DEFINITIONS

Benefit Period means the period as determined by Medicare which begins on the date, You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

Emergency Care means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

Hospital means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or Hospitalization means being confined in a Hospital on an inpatient basis.

Immediate Family means Your spouse; parents; grandparents; children; or siblings, and their spouses.

Injury means a bodily injury which is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

Medicaid means the medical assistance program under Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A Initial Deductible means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

Policy Effective Date means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

Sickness means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

The benefits paid under this Policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61st) day through the ninetieth (90th) day in any Medicare Benefit Period.

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider will accept Our payment as payment in full and may not bill You for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital Confinement, subject to the Medicare Part B deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare Eligible Expenses for hospice care and respite care expenses.

Additional Benefits For Plan "D"

Medicare Part A Deductible: Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21st) day through the one hundredth (100th) day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000).

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare deductibles, copayment or coinsurance amounts. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the PREMIUMS SUBJECT TO CHANGE provision on page 1.

**MEDICAL ASSISTANCE UNDER MEDICAID
AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. No waiting period with respect to treatment of preexisting conditions.
2. Coverage equivalent to coverage in effect before the date of suspension; and
3. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

EXTENSION OF BENEFITS

Upon termination of this Policy, an extension of benefits will be granted for any continuous loss which commenced during a period where the Policy was in force and the premium was paid. This extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

EXCLUSIONS

We will not pay benefits for:

- (a) Expenses incurred while this policy is not in force except as provided in the Extension of Benefits section;
- (b) Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
- (c) That portion of any expense incurred which is paid for by Medicare;
- (d) Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions;
- (e) Services for which a charge is not normally made in the absence of insurance; or
- (f) Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, including the endorsements and attached documents if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After three (3) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the three (3) year period.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of each premium due after the initial premium. The Policy will remain in force during the grace period. If the premium is not paid during the grace period, coverage will terminate as of the date the premium was due and claims incurred on or after that date will not be considered for payment. A grace period does not apply if You cancel Your Policy.

REINSTATEMENT: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from Injury or Sickness as may begin on or after the date of reinstatement. In all other respects the Company and the Insured shall have the same rights under the Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Heartland National Life Insurance Company, Medicare Supplement Claims Processing Center, [P.O. Box 10813 Clearwater, Florida 33757-8813].

CLAIM FORMS: When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

PROOF OF LOSS: We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

We shall pay interest to You equal to twelve percent (12%) per annum on the proceeds or benefits due under the terms of this Policy for failure to comply with the requirements of this provision.

GENERAL POLICY PROVISIONS CONTINUED

ELECTRONIC CLAIM FILING PROCESS: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and Hospital expenses You incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and then passes Your claim electronically to Us for consideration of benefits under Your Medicare Supplement Policy. We will accept Medicare's electronic submission of Your claim to Us as Your notice of claim. For consideration of expenses that are not submitted electronically to Us Your Medicare Summary Notice or Medicare Benefit Notice can serve as Your notice of claim. This Medicare statement shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare statement to Us or Your health care provider may submit it to Us on Your behalf.

PHYSICAL EXAMINATIONS: At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE LAWS: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Heartland National Life Insurance Company, Medicare Supplement Claims Processing Center, [P.O. Box 10813 Clearwater, Florida 33757-8813.]

CLERICAL ERROR: Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

MISSTATEMENT OF AGE: If Your age has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

PRO RATA REFUND: If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

CANCELLATION BY INSURED: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation except as provided for under the Extension of Benefits provision.

This Policy is signed for Heartland National Life Insurance Company by its President.

[SIGNATURE]

[PRESIDENT]

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: [Indianapolis, Indiana 46280]

MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN F

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US

READ YOUR POLICY CAREFULLY

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We," "Our" and "Us" means Heartland National Life Insurance Company.

NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

IMPORTANT NOTICE: Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Medicare Supplement Administrative Office at:

**[P.O. Box 10814]
[Clearwater, Florida 33757-8814]
[877-431-7371]**

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at 12:01 A.M. Standard Time, at the place where You reside, on the Policy Effective Date shown on the Policy Schedule. It ends at 12:00 o'clock midnight, Standard Time, at the place where You reside, on the day before Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule.

THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

GUARANTEED RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state and zip code of residence. Any change in Premium will occur on your Policy Anniversary Date. Your Policy Anniversary Date is the same month and day as the Policy Effective Date for each succeeding year this Policy remains in force. We will give You the advance written notice required by Your state prior to any premium change.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION

THIS IS A NON-PARTICIPATING POLICY

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POLICYHOLDER INFORMATION

For support and information regarding policy terms, premium payments, claims processing and payment, contact us at:

Medicare Supplement Administration
[P. O. Box 10814]
[Clearwater, Florida 33757-8814]
[1-877-431-7371]

For your information, the following is the name, address and telephone number of your agent:

The Arkansas Insurance Department can be contacted at:

Arkansas Insurance Department
Consumer Services
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-501-371-2640

Toll Free Consumer Information Telephone Number
1-800-852-5494

POLICY SCHEDULE

INSURED:

POLICY EFFECTIVE DATE:

POLICY NUMBER:

ISSUE AGE:

STATE OF ISSUE:

MODE AT ISSUE:

MODAL PREMIUM:

PREMIUM TERM:

UNDERWRITING CLASS:

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN F

DEFINITIONS

Benefit Period means the period as determined by Medicare which begins on the date, You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

Emergency Care means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

Hospital means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or Hospitalization means being confined in a Hospital on an inpatient basis.

Immediate Family means Your spouse; parents; grandparents; children; or siblings, and their spouses.

Injury means a bodily injury which is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

Medicaid means the medical assistance program under Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A Initial Deductible means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

Medicare Part B Deductible means the fixed amount You must pay each calendar year before Medicare starts paying Part B expenses. This amount is set each year by Medicare. Medicare does not pay this amount. A Calendar Year begins on January 1 and ends on December 31.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

Policy Effective Date means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

DEFINITIONS CONTINUED

Sickness means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

The benefits paid under this Policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61st) day through the ninetieth (90th) day in any Medicare Benefit Period.

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider will accept Our payment as payment in full and may not bill You for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital Confinement, subject to the Medicare Part B deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare Eligible Expenses for hospice care and respite care expenses.

Additional Benefits For Plan "F"

Medicare Part A Deductible: Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21st) day through the one hundredth (100th) day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

Medicare Part B Deductible: Coverage for all of the Medicare Part B Deductible amount per Calendar Year regardless of Hospital confinement.

Additional Benefits For Plan "F" Continued

One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, 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: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000).

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare deductibles, copayment or coinsurance amounts. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the PREMIUMS SUBJECT TO CHANGE provision on page 1.

MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. No waiting period with respect to treatment of preexisting conditions.
2. Coverage equivalent to coverage in effect before the date of suspension; and
3. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

EXTENSION OF BENEFITS

Upon termination of this Policy, an extension of benefits will be granted for any continuous loss which commenced during a period where the Policy was in force and the premium was paid. This extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

EXCLUSIONS

We will not pay benefits for:

- (a) Expenses incurred while this policy is not in force except as provided in the Extension of Benefits section;
- (b) Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
- (c) That portion of any expense incurred which is paid for by Medicare;
- (d) Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions;
- (e) Services for which a charge is not normally made in the absence of insurance; or
- (f) Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, including the endorsements and attached documents if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After three (3) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the three (3) year period.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of each premium due after the initial premium. The Policy will remain in force during the grace period. If the premium is not paid during the grace period, coverage will terminate as of the date the premium was due and claims incurred on or after that date will not be considered for payment. A grace period does not apply if You cancel Your Policy.

REINSTATEMENT: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from Injury or Sickness as may begin on or after the date of reinstatement. In all other respects the Company and the Insured shall have the same rights under the Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Heartland National Life Insurance Company, Medicare Supplement Claims Processing Center, [P.O. Box 10813 Clearwater, Florida 33757-8813.]

CLAIM FORMS: When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

GENERAL POLICY PROVISIONS CONTINUED

PROOF OF LOSS: We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

We shall pay interest to You equal to twelve percent (12%) per annum on the proceeds or benefits due under the terms of this Policy for failure to comply with the requirements of this provision.

ELECTRONIC CLAIM FILING PROCESS: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and Hospital expenses You incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and then passes Your claim electronically to Us for consideration of benefits under Your Medicare Supplement Policy. We will accept Medicare's electronic submission of Your claim to Us as Your notice of claim. For consideration of expenses that are not submitted electronically to Us Your Medicare Summary Notice or Medicare Benefit Notice can serve as Your notice of claim. This Medicare statement shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare statement to Us or Your health care provider may submit it to Us on Your behalf.

PHYSICAL EXAMINATIONS: At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE LAWS: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Heartland National Life Insurance Company, Medicare Supplement Claims Processing Center, [P.O. Box 10813 Clearwater, Florida 33757-8813.]

CLERICAL ERROR: Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

GENERAL POLICY PROVISIONS CONTINUED

MISSTATEMENT OF AGE: If Your age has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

PRO RATA REFUND: If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

CANCELLATION BY INSURED: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation except as provided for under the Extension of Benefits provision.

This Policy is signed for Heartland National Life Insurance Company by its President.

[SIGNATURE]

[PRESIDENT]

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: [Indianapolis, Indiana 46280]

MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN G

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US

READ YOUR POLICY CAREFULLY

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We," "Our" and "Us" means Heartland National Life Insurance Company.

NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

IMPORTANT NOTICE: Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Medicare Supplement Administrative Office at:

**[P.O. Box 10814
[Clearwater, Florida 33757-8814]
[877-431-7371]**

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at 12:01 A.M. Standard Time, at the place where You reside, on the Policy Effective Date shown on the Policy Schedule. It ends at 12:00 o'clock midnight, Standard Time, at the place where You reside, on the day before Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule.

THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

GUARANTEED RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state and zip code of residence. Any change in Premium will occur on your Policy Anniversary Date. Your Policy Anniversary Date is the same month and day as the Policy Effective Date for each succeeding year this Policy remains in force. We will give You the advance written notice required by Your state prior to any premium change.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION

THIS IS A NON-PARTICIPATING POLICY

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POLICYHOLDER INFORMATION

For support and information regarding policy terms, premium payments, claims processing and payment, contact us at:

Medicare Supplement Administration
[P. O. Box 10813
[Clearwater, Florida 33757-8813]
1-877-431-7371]

For your information, the following is the name, address and telephone number of your agent:

The Arkansas Insurance Department can be contacted at:

Arkansas Insurance Department
Consumer Services
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-501-371-2640

Toll Free Consumer Information Telephone Number
1-800-852-5494

POLICY SCHEDULE

INSURED:

POLICY EFFECTIVE DATE:

POLICY NUMBER:

ISSUE AGE:

STATE OF ISSUE:

MODE AT ISSUE:

MODAL PREMIUM:

PREMIUM TERM:

UNDERWRITING CLASS:

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN G

DEFINITIONS

Benefit Period means the period as determined by Medicare which begins on the date, You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

Emergency Care means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

Hospital means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or Hospitalization means being confined in a Hospital on an inpatient basis.

Immediate Family means Your spouse; parents; grandparents; children; or siblings, and their spouses.

Injury means a bodily injury which is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

Medicaid means the medical assistance program under Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A Initial Deductible means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

Policy Effective Date means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

Sickness means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

The benefits paid under this Policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61st) day through the ninetieth (90th) day in any Medicare Benefit Period.

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider will accept Our payment as payment in full and may not bill You for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital Confinement, subject to the Medicare Part B deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare Eligible Expenses for hospice care and respite care expenses.

Additional Benefits For Plan "G"

Medicare Part A Deductible: Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21st) day through the one hundredth (100th) day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for one hundred percent (100%) of the difference between the actual Medicare Part B charge as billed, 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: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000).

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare deductibles, copayment or coinsurance amounts. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the PREMIUMS SUBJECT TO CHANGE provision on page 1.

MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of Your coverage provides for:

1. No waiting period with respect to treatment of preexisting conditions.
2. Coverage equivalent to coverage in effect before the date of suspension; and
3. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

EXTENSION OF BENEFITS

Upon termination of this Policy, an extension of benefits will be granted for any continuous loss which commenced during a period where the Policy was in force and the premium was paid. This extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

EXCLUSIONS

We will not pay benefits for:

- (a) Expenses incurred while this policy is not in force except as provided in the Extension of Benefits section;
- (b) Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
- (c) That portion of any expense incurred which is paid for by Medicare;
- (d) Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions;
- (e) Services for which a charge is not normally made in the absence of insurance; or
- (f) Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, including the endorsements and attached documents if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After three (3) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the three (3) year period.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of each premium due after the initial premium. The Policy will remain in force during the grace period. If the premium is not paid during the grace period, coverage will terminate as of the date the premium was due and claims incurred on or after that date will not be considered for payment. A grace period does not apply if You cancel Your Policy.

REINSTATEMENT: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from Injury or Sickness as may begin on or after the date of reinstatement. In all other respects the Company and the Insured shall have the same rights under the Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Heartland National Life Insurance Company, Medicare Supplement Claims Processing [Center, [P.O. Box 10813 Clearwater, Florida 33757-8813.]

CLAIM FORMS: When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

PROOF OF LOSS: We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

We shall pay interest to You equal to twelve percent (12%) per annum on the proceeds or benefits due under the terms of this Policy for failure to comply with the requirements of this provision.

GENERAL POLICY PROVISIONS CONTINUED

ELECTRONIC CLAIM FILING PROCESS: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and Hospital expenses You incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and then passes Your claim electronically to Us for consideration of benefits under Your Medicare Supplement Policy. We will accept Medicare's electronic submission of Your claim to Us as Your notice of claim. For consideration of expenses that are not submitted electronically to Us Your Medicare Summary Notice or Medicare Benefit Notice can serve as Your notice of claim. This Medicare statement shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare statement to Us or Your health care provider may submit it to Us on Your behalf.

PHYSICAL EXAMINATIONS: At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE LAWS: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Heartland National Life Insurance Company, Medicare Supplement Claims Processing Center, [P.O. Box 10813 Clearwater, Florida 33757-8813].

CLERICAL ERROR: Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

MISSTATEMENT OF AGE: If Your age has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

PRO RATA REFUND: If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

CANCELLATION BY INSURED: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation except as provided for under the Extension of Benefits provision.

This Policy is signed for Heartland National Life Insurance Company by its President.

[SIGNATURE]

[PRESIDENT]

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: [Indianapolis, Indiana 46280]

MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN M

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US

READ YOUR POLICY CAREFULLY

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We," "Our" and "Us" means Heartland National Life Insurance Company

NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

IMPORTANT NOTICE: Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Medicare Supplement Administrative Office at:

**[P.O. Box 10814]
[Clearwater, Florida 33757-8814]
[877-431-7371]**

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at 12:01 A.M. Standard Time, at the place where You reside, on the Policy Effective Date shown on the Policy Schedule. It ends at 12:00 o'clock midnight, Standard Time, at the place where You reside, on the day before Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule.

THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

GUARANTEED RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state and zip code of residence. Any change in Premium will occur on your Policy Anniversary Date. Your Policy Anniversary Date is the same month and day as the Policy Effective Date for each succeeding year this Policy remains in force. We will give You the advance written notice required by Your state prior to any premium change.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION

THIS IS A NON-PARTICIPATING POLICY

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POLICYHOLDER INFORMATION

For support and information regarding arkansas terms, premium payments, claims processing and payment, contact us at:

Medicare Supplement Administration
[P. O. Box 10814]
[Clearwater, Florida 33757-8814]
[1-877-431-7371]

For your information, the following is the name, address and telephone number of your agent:

The Arkansas Insurance Department can be contacted at:

Arkansas Insurance Department
Consumer Services
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-501-371-2640

Toll Free Consumer Information Telephone Number
1-800-852-5494

POLICY SCHEDULE

INSURED:

POLICY EFFECTIVE DATE:

POLICY NUMBER:

ISSUE AGE:

STATE OF ISSUE:

MODE AT ISSUE:

MODAL PREMIUM:

PREMIUM TERM:

UNDERWRITING CLASS:

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN M

DEFINITIONS

Benefit Period means the period as determined by Medicare which begins on the date, You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

Emergency Care means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

Hospital means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or Hospitalization means being confined in a Hospital on an inpatient basis.

Immediate Family means Your spouse; parents; grandparents; children; or siblings, and their spouses.

Injury means a bodily injury which is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

Medicaid means the medical assistance program under Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A Initial Deductible means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

Policy Effective Date means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

Sickness means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

The benefits paid under this Policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61st) day through the ninetieth (90th) day in any Medicare Benefit Period.

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider will accept Our payment as payment in full and may not bill You for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital Confinement, subject to the Medicare Part B deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare Eligible Expenses for hospice care and respite care expenses.

Additional Benefits For Plan "M"

Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A Initial Deductible amount per Benefit Period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21st) day through the one hundredth (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: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000).

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare deductibles, copayment or coinsurance amounts. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the PREMIUMS SUBJECT TO CHANGE provision on page 1.

MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of Your coverage provides for:

1. No waiting period with respect to treatment of preexisting conditions.
2. Coverage equivalent to coverage in effect before the date of suspension; and
3. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

EXTENSION OF BENEFITS

Upon termination of this Policy, an extension of benefits will be granted for any continuous loss which commenced during a period where the Policy was in force and the premium was paid. This extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

EXCLUSIONS

We will not pay benefits for:

- (a) Expenses incurred while this policy is not in force except as provided in the Extension of Benefits section;
- (b) Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
- (c) That portion of any expense incurred which is paid for by Medicare;
- (d) Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions;
- (e) Services for which a charge is not normally made in the absence of insurance; or
- (f) Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, including the endorsements and attached documents if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After three (3) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the three (3) year period.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of each premium due after the initial premium. The Policy will remain in force during the grace period. If the premium is not paid during the grace period, coverage will terminate as of the date the premium was due and claims incurred on or after that date will not be considered for payment. A grace period does not apply if You cancel Your Policy.

REINSTATEMENT: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from Injury or Sickness as may begin on or after the date of reinstatement. In all other respects the Company and the Insured shall have the same rights under the Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Heartland National Life Insurance Company, Medicare Supplement Claims Processing Center, [P.O. Box 10813 Clearwater, Florida 33757-8813.]

CLAIM FORMS: When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

PROOF OF LOSS: We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

We shall pay interest to You equal to twelve percent (12%) per annum on the proceeds or benefits due under the terms of this Policy for failure to comply with the requirements of this provision.

GENERAL POLICY PROVISIONS CONTINUED

ELECTRONIC CLAIM FILING PROCESS: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and Hospital expenses You incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and then passes Your claim electronically to Us for consideration of benefits under Your Medicare Supplement Policy. We will accept Medicare's electronic submission of Your claim to Us as Your notice of claim. For consideration of expenses that are not submitted electronically to Us Your Medicare Summary Notice or Medicare Benefit Notice can serve as Your notice of claim. This Medicare statement shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare statement to Us or Your health care provider may submit it to Us on Your behalf.

PHYSICAL EXAMINATIONS: At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE LAWS: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Heartland National Life Insurance Company, Medicare Supplement Claims Processing Center, [P.O. Box 10813 Clearwater, Florida 33757-8813.]

CLERICAL ERROR: Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

MISSTATEMENT OF AGE: If Your age has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

PRO RATA REFUND: If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

CANCELLATION BY INSURED: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation except as provided for under the Extension of Benefits provision.

This Policy is signed for Heartland National Life Insurance Company by its President.

[SIGNATURE]

[PRESIDENT]

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
Home Office: [Indianapolis, Indiana 46280]

MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN N

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US

READ YOUR POLICY CAREFULLY

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We," "Our" and "Us" means Heartland National Life Insurance Company.

NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

IMPORTANT NOTICE: Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Medicare Supplement Administrative Office at:

[P.O. Box 10813]
[Clearwater, Florida 33757-10813]
[877-431-7371]

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at 12:01 A.M. Standard Time, at the place where You reside, on the Policy Effective Date shown on the Policy Schedule. It ends at 12:00 o'clock midnight, Standard Time, at the place where You reside, on the day before Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule.

THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

GUARANTEED RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state and zip code of residence. Any change in Premium will occur on your Policy Anniversary Date. Your Policy Anniversary Date is the same month and day as the Policy Effective Date for each succeeding year this Policy remains in force. We will give You the advance written notice required by Your state prior to any premium change.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION

THIS IS A NON-PARTICIPATING POLICY

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POLICYHOLDER INFORMATION

For support and information regarding policy terms, premium payments, claims processing and payment, contact us at:

Medicare Supplement Administration
[P. O. Box 10813]
[Clearwater, Florida 33757-10813]
[1-877-431-7371]

For your information, the following is the name, address and telephone number of your agent:

The Arkansas Insurance Department can be contacted at:

Arkansas Insurance Department
Consumer Services
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-501-371-2640

Toll Free Consumer Information Telephone Number
1-800-852-5494

POLICY SCHEDULE

INSURED:

POLICY EFFECTIVE DATE:

POLICY NUMBER:

ISSUE AGE:

STATE OF ISSUE:

MODE AT ISSUE:

MODAL PREMIUM:

PREMIUM TERM:

UNDERWRITING CLASS:

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN N

DEFINITIONS

Benefit Period means the period as determined by Medicare, which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

Emergency Care means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

Hospital means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or Hospitalization means being confined in a Hospital on an inpatient basis.

Immediate Family means Your spouse; parents; grandparents; children; or siblings, and their spouses.

Injury means a bodily injury which is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

Medicaid means the medical assistance program under Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A Initial Deductible means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

Policy Copayment is the fixed amount the Policy will not pay for specified Medicare Part B expenses after the Medicare Part B Deductible has been met. This Policy Copayment will change in accordance with applicable law and regulation. You are responsible to pay the Policy Copayments.

Policy Effective Date means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

DEFINITIONS CONTINUED

Sickness means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

The benefits paid under this Policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61st) day through the ninetieth (90th) day in any Medicare Benefit Period.

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider will accept Our payment as payment in full and may not bill You for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital Confinement, subject to the Medicare Part B deductible and copayment amounts described below. You are responsible to pay:

1. the lesser of the Policy Copayment or the Medicare Part B coinsurance/copayment for each covered health care provider office visit (including visits to medical specialists); and
2. the lesser of the Policy Copayment or the Medicare Part B coinsurance/copayment for each covered emergency room visit. The emergency room copayment will be waived if You are admitted to any Hospital and the emergency room visit is subsequently covered as a Medicare Part A expense.

Hospice Care: Coverage of cost sharing for all Part A Medicare Eligible Expenses for hospice care and respite care expenses.

Additional Benefits For Plan "N"

Medicare Part A Deductible: Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21st) day through the one hundredth (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: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000).

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare deductibles, copayment or coinsurance amounts. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the PREMIUMS SUBJECT TO CHANGE provision on page 1.

MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. No waiting period with respect to treatment of preexisting conditions.
2. Coverage equivalent to coverage in effect before the date of suspension; and
3. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

EXTENSION OF BENEFITS

Upon termination of this Policy, an extension of benefits will be granted for any continuous loss which commenced during a period where the Policy was in force and the premium was paid. This extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

EXCLUSIONS

We will not pay benefits for:

- (a) Expenses incurred while this policy is not in force except as provided in the Extension of Benefits section;
- (b) Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
- (c) That portion of any expense incurred which is paid for by Medicare;
- (d) Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions;
- (e) Services for which a charge is not normally made in the absence of insurance; or
- (f) Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, including the endorsements and attached documents if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After three (3) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the three (3) year period.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of each premium due after the initial premium. The Policy will remain in force during the grace period. If the premium is not paid during the grace period, coverage will terminate as of the date the premium was due and claims incurred on or after that date will not be considered for payment. A grace period does not apply if You cancel Your Policy.

REINSTATEMENT: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from Injury or Sickness as may begin on or after the date of reinstatement. In all other respects the Company and the Insured shall have the same rights under the Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Heartland National Life Insurance Company, Medicare Supplement Claims Processing Center, [P.O. Box 10813 Clearwater, Florida 33757-8813.]

GENERAL POLICY PROVISIONS CONTINUED

CLAIM FORMS: When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

PROOF OF LOSS: We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

We shall pay interest to You equal to twelve percent (12%) per annum on the proceeds or benefits due under the terms of this Policy for failure to comply with the requirements of this provision.

ELECTRONIC CLAIM FILING PROCESS: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and Hospital expenses You incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and then passes Your claim electronically to Us for consideration of benefits under Your Medicare Supplement Policy. We will accept Medicare's electronic submission of Your claim to Us as Your notice of claim. For consideration of expenses that are not submitted electronically to Us Your Medicare Summary Notice or Medicare Benefit Notice can serve as Your notice of claim. This Medicare statement shows Your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of Your Medicare statement to Us or Your health care provider may submit it to Us on Your behalf.

PHYSICAL EXAMINATIONS: At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE LAWS: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date, is hereby amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Heartland National Life Insurance Company, Medicare Supplement Claims Processing Center, [P.O. Box 10813 Clearwater, Florida 33757-8813.]

GENERAL POLICY PROVISIONS CONTINUED

CLERICAL ERROR: Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

MISSTATEMENT OF AGE: If Your age has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

PRO RATA REFUND: If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

CANCELLATION BY INSURED: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation except as provided for under the Extension of Benefits provision.

This Policy is signed for Heartland National Life Insurance Company by its President.

[SIGNATURE]

[PRESIDENT]

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: [Indianapolis, Indiana 46280]

Medicare Supplement Administrative Office: [PO Box 10812, Clearwater, FL 33757-8812]

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

Application #:	
Applicant (Exactly as shown on your Medicare ID Card)	Residence Address:
Last	Street
First MI	City
Indicate the Medicare Supplement Plan Applied for:	State Zip Code
Plan: _____	Phone: (_____) _____ - _____

SOCIAL SECURITY NUMBER	MEDICARE CLAIM NUMBER

AGE	DATE OF BIRTH	GENDER	HEIGHT	WEIGHT
	<i>Month Day Year</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ ft _____ in	_____ lbs

PREMIUM PAYMENT

Modal Premium: \$ _____

Total Submitted Premium: \$ _____ Requested Effective Date: _____

or Draft Initial Premium

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

Annual Semiannual Quarterly Monthly Bank Draft

I authorize Bank Draft payments. Account Type: Checking Amount to be drafted: \$ _____
 Savings

Bank Routing # (9 digits): _____ Bank Account # (do not include check #): _____ Select Bank Draft Day: (Cannot be more than 10 days beyond effective day)

Bank Name: _____

Name(s) of Depositor(s): _____

Signature of Depositor: _____ Date: _____

Please include a voided check on a separate sheet of paper.

PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

1. Are you covered under Medicare Part A? Yes No
If YES, what is your Part A effective date? ____/____/____
If NO, what is your eligibility date? ____/____/____
2. Are you covered under Medicare Part B? Yes No
If YES, what is your Part B effective date? ____/____/____
If NO, what is your eligibility date? ____/____/____
3. Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility). Yes No

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, answer a-b below.
- (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 ____/____/____
If YES, with which company _____
Company telephone number: _____ Policy number: _____
- (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 this Medicare plan? Yes No

MEDICARE & INSURANCE INFORMATION (Continued)

5. (a) Do you have another Medicare Supplement policy in force? Yes No
(b) If yes with which company: _____
with which plan: _____
what paid-to-date do you have? ____/____/____
Company telephone number: _____
(c) If yes, 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 which company : _____
what kind of policy _____
what paid-to-date do you have? ____/____/____
Company telephone number: _____
(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).

HEALTH QUESTIONS

(You do not have to answer these questions if you are applying during open enrollment or a guaranteed issue period)

Have you used tobacco in any form in the past 12 months?

Yes No

Do not answer health questions 1-15 if you are in an open enrollment or guaranteed issue period. Please see page 6 for an explanation of open enrollment /guaranteed issue period information.

NOTICE TO APPLICANT: Please answer all of the following questions. Please verify the accuracy and completeness of the medical information on this application. Incomplete or false information on this application could jeopardize future claims. If you answer YES to any of the following questions 1 - 14, you are not eligible for coverage.

1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? Yes No
2. Have you been diagnosed with emphysema, chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disorders? Yes No
3. Have you been diagnosed with Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with fractures, cirrhosis or kidney disease requiring dialysis? Yes No
4. Have you been diagnosed with Alzheimer's disease, senile dementia, or any other cognitive disorder? Yes No
5. Have you been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)? Yes No
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), or kidney disease? If you do **not** have diabetes, this question should be answered "NO." Yes No
7. Do you have diabetes that has ever required more than 50 units of insulin daily? Yes No
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? Yes No
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? Yes No
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes No
11. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts? Yes No
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes No
13. Have you been hospital confined three or more times in the last two years? Yes No
14. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes No

HEALTH QUESTIONS Continued

15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If YES, please list the drug(s) below along with the date prescribed, dosage/frequency and diagnosis/medical condition for **each** medication. Attach a separate sheet if needed.

Yes No

Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/ Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	

PRIMARY CARE PHYSICIAN INFORMATION

Physician's Name: _____

Telephone Number: _____

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-15 on pages 4 and 5 of this application if (a) you are within six months of age 65 and purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are now 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) provides health benefits that supplement the benefits under Medicare and the plan terminates or the plan ceases to provide some or all such supplemental benefits to the individual; or (2) the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual; or (3) the individual leaves the plan whether the plan is primary or secondary with Medicare.; or
- (b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, 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 terminates coverage within 12 months of enrollment; or
- (f) Upon *first* becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months.

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.

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, 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 #1 Name (please print)	Agent #	Split %
Agent #2 Signature	Date	
Agent #2 Name (please print)	Agent #	Split %

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Heartland National Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Heartland National Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Heartland National Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Heartland National Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Heartland National Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Heartland National Life Insurance Company in writing at their Medicare Supplement Administrative Office: [P.O. Box 10812, Clearwater, Florida 33757-8812]. I understand that such revocation will not have any effect on actions Heartland National Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

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 until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

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 wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at: _____
State Applicant's Signature Date

This section to be completed by an agent.

Signed at: _____
State Writing Agent's Signature and Agent Number Date

Policy Mailing Preference: Mail to Agent Mail to Applicant

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Outline of Medicare Supplement Coverage

Benefit Plans A, D, F, G, M, and N

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state. [Plans E, H, I, and J are no longer available for sale.]

Basic Benefits:

- 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 copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- Blood – First three pints of blood each year.
- Hospice – Part A coinsurance

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100 % Part B coinsurance except up to \$20 copayment for office visit, and up to \$50 copayment for ER			
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				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
							Out-of-pocket limit [\$4620] paid at 100% after limit reached	Out-of-Pocket limit [\$2310] paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$[2000]. 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.

Effective [mm-dd-yyyy]

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

[RATES]

PREMIUM INFORMATION

Heartland National Life Insurance Company may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state and zip code of residence.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

[This outline shows benefits and premiums of Policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.]

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 Heartland National Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your Policy, you may return it to: Heartland National Life Insurance Company, Medicare Supplement Administration, [P.O. Box 10814, Clearwater, Florida 33757-8814]. 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 Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

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. Heartland National Life Insurance 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.

Please refer to your Policy for details.

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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>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</p>	<p>All but \$[1100]</p> <p>All but \$[275] a day</p> <p>All but \$[550] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$[275] a day</p> <p>\$[550] a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$[1100] (Part A deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* 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</p> <p>First 20 days 21st thru 100th day 101st day and after</p>	<p>All approved amounts</p> <p>All but \$[137.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$[137.50] a day</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.</p>	<p>All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</p>

****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 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

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[155] (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[155] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[155] (Part B deductible) \$0

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100] (Part A deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* 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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$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 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

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$[155] (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[155] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN D
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	[\$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1100]	\$[1100] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after:			
— While using 60 lifetime reserve days	All but \$[550] a day	\$[550] a day	\$0
— Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* 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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$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 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

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN F
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
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 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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100] (Part A deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* 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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$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 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

MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[155] (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[155] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN G
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	[\$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
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 M

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1100]	\$[550] (50% of Part A deductible)	\$[550] (50% of Part A deductible)
61 st thru 90 th day 91 st day and after:	All but \$[275] a day	\$[275] a day	\$0
— While using 60 lifetime reserve days — Once lifetime reserve days are used:	All but \$[550] a day	\$[550] a day	\$0
— Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* 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	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[137.50] a day	Up to \$[137.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$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 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 M

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$[155] (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$[155] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN M
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
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 N

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100] (Part A deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* 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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$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 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 N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,</p> <p>First \$[155] of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>Generally 80%</p>	<p>\$0</p> <p>Balance, other than up to \$[20] per office visit and up to \$[50] per emergency visit. The co-payment of up to \$[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</p>	<p>\$[155] (Part B deductible)</p> <p>Up to \$[20] per office visit and up to \$[50] per emergency visit. The co-payment of up to \$[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</p>
<p>PART B EXCESS CHARGES (Above Medicare Approved Amounts)</p>	\$0	\$0	All costs
<p>BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$0</p> <p>20%</p>	<p>\$0</p> <p>\$[155] (Part B deductible)</p> <p>\$0</p>
<p>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</p>	100%	\$0	\$0

(continued)

**PLAN N
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
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: [Indianapolis, Indiana 46280]

Medicare Supplement Administrative Office: [PO Box 10812, Clearwater, FL 33757-8812]

REINSTATEMENT APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

POLICY NUMBER TO REINSTATE:

Applicant (Exactly as shown on your Medicare ID Card)		Residence Address:	
Last		Street	
First	MI	City	
		State	Zip Code
Phone: (_____) _____ - _____			

SOCIAL SECURITY NUMBER	MEDICARE CLAIM NUMBER

AGE	DATE OF BIRTH	GENDER	HEIGHT	WEIGHT
	<i>Month Day Year</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ ft _____ in	_____ lbs

HEALTH QUESTIONS

NOTICE TO APPLICANT: Please answer all of the following questions. Please verify the accuracy and completeness of the medical information on this application. Incomplete or false information on this application could jeopardize future claims. If you answer YES to any of the following questions 1 - 14, you are not eligible for reinstatement.

1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? Yes No
2. Have you been diagnosed with emphysema, chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disorders? Yes No
3. Have you been diagnosed with Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with fractures, cirrhosis or kidney disease requiring dialysis? Yes No
4. Have you been diagnosed with Alzheimer's disease, senile dementia, or any other cognitive disorder? Yes No
5. Have you been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)? Yes No
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), or kidney disease? If you do **not** have diabetes, this question should be answered "NO." Yes No
7. Do you have diabetes that has ever required more than 50 units of insulin daily? Yes No
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? Yes No
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? Yes No
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes No
11. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts? Yes No
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes No
13. Have you been hospital confined three or more times in the last two years? Yes No
14. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes No

HEALTH QUESTIONS Continued

15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If YES, please list the drug(s) below along with the date prescribed, dosage/frequency and diagnosis/medical condition for **each** medication. Attach a separate sheet if needed.

Yes No

Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/ Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	

PRIMARY CARE PHYSICIAN INFORMATION	
Physician's Name:	_____
Telephone Number:	_____

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Heartland National Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Heartland National Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Heartland National Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Heartland National Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Heartland National Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Heartland National Life Insurance Company in writing at their Medicare Supplement Administrative Office: [P.O. Box 10812, Clearwater, Florida 33757-8812]. I understand that such revocation will not have any effect on actions Heartland National Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

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 until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

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 wish to reinstate my Medicare supplement insurance policy.

Signed at:

_____ State

_____ Applicant's Signature

_____ Date

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

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: [Indianapolis, Indiana 46280]

Medicare Supplement Administrative Office: [P. O. Box 10812 Clearwater, Florida 33757-8812]

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 insurance 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.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate 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. No change in benefits, but lower premiums
- Fewer benefits and lower premiums.
- Change in benefits (Gaining additional benefit(s), but losing some existing benefit(s)).
- My plan has outpatient drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.
- _____
- Other (please specify) _____

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 company 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.

Signature of Agent, Broker or Other Representative

Agent's Printed Name and Address

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature

Date

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
Home Office: [Indianapolis, Indiana 46280]

Mail To:
HEARTLAND NATIONAL LIFE INSURANCE COMPANY
Administrative Office
[P.O. Box 10812]
[Clearwater, Florida 33757-8812]

AMENDMENT TO APPLICATION

I hereby agree that the following changes noted below shall be an amendment to and form a part of the application for Policy Number _____ and shall be binding on any person who shall have or claim any interest under such policy.

Acceptance is acknowledged by:

Insured

Date

[SIGNATURE]

[President]

SERFF Tracking Number: IASL-126823909 State: Arkansas
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 46879
 Company Tracking Number: HNMSAA2010AR
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
 Standard Plans 2010
 Product Name: HN AR 2010 Forms
 Project Name/Number: HN AR 2010 Forms/

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved 10/14/2010	Rate Sheets	HNMSAA2010AR New , HNMSDA2010AR , HNMSFA2010AR , HNMSGGA2010A R, HNMSMA2010A R, HNMSNA2010AR			RateSheet_AR.pdf

Heartland National Life Insurance Company
Standardized Medicare Supplement Premium Rates
 Effective - 12/1/2010

ARKANSAS

Annual Rates

	Non-Tobacco							Tobacco					
Age	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N		Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	1,260.00	1,641.60	1,784.40	1,668.00	1,531.20	1,294.80		1,260.00	1,641.60	1,784.40	1,668.00	1,531.20	1,294.80

Monthly Rates

	Non-Tobacco							Tobacco					
Age	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N		Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	105.00	136.80	148.70	139.00	127.60	107.90		116.70	152.00	165.30	154.40	141.80	119.90

Zip Codes

Area Factors

720-722	1.00
716-719, 723-729	0.90

SERFF Tracking Number: IASL-126823909 State: Arkansas
 Filing Company: Heartland National Life Insurance Company State Tracking Number: 46879
 Company Tracking Number: HNMSAA2010AR
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
 Standard Plans 2010
 Product Name: HN AR 2010 Forms
 Project Name/Number: HN AR 2010 Forms/

Supporting Document Schedules

Satisfied - Item:	Flesch Certification	Item Status:	Accepted for Informational Purposes	Status Date:	10/14/2010
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Comments:

Attachment:

Flesch Cert - IA.pdf

Satisfied - Item:	Application	Item Status:	Approved	Status Date:	10/14/2010
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Comments:

A new application is provided.

Satisfied - Item:	Outline of Coverage	Item Status:	Approved	Status Date:	10/14/2010
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Comments:

Outline of Coverage is provided.

Satisfied - Item:	Letter of Authorizatoin	Item Status:	Accepted for Informational Purposes	Status Date:	10/14/2010
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Comments:

Attachment:

2010 09 Heartland IAS Authorization Letter.pdf

Satisfied - Item:	Explanation of Variability for	Item Status:	Approved	Status Date:	10/14/2010
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SERFF Tracking Number: IASL-126823909 *State:* Arkansas
Filing Company: Heartland National Life Insurance Company *State Tracking Number:* 46879
Company Tracking Number: HNMSAA2010AR
TOI: MS08I Individual Medicare Supplement - *Sub-TOI:* MS08I.001 Plan A 2010
Standard Plans 2010
Product Name: HN AR 2010 Forms
Project Name/Number: HN AR 2010 Forms/
Amendment to Application

Comments:

Attachment:

Variable Lang HN-ATA.pdf

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

**Heartland National Life Insurance Company
10689 N. Pennsylvania Street
Indianapolis, Indiana 46280**

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

TYPE/TITLE OF FORM	FORM NUMBERS	FLESCH SCORE
Medicare Supplement Policy – Plan A	HNMSAI2010AR	50.0
Medicare Supplement Policy – Plan D	HNMSDI2010AR	50.0
Medicare Supplement Policy – Plan F	HNMSFI2010AR	50.2
Medicare Supplement Policy – Plan G	HNMSGI2010AR	50.2
Medicare Supplement Policy – Plan M	HNMSMI2010AR	50.5
Medicare Supplement Policy – Plan N	HNMSNI2010AR	51.1
Medicare Supplement Application	HNAPP2010AR	Scored as a part of the policy.

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

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



Chris McDaniel, President & CEO.

September 23, 2010

HEARTLAND  NATIONAL
Life Insurance Company

1600 NE Coronado Drive
Blue Springs, Missouri 64014

Phone: 816 478-0120
Fax: 816 655-5076

September 8, 2010

Ms. Darcey Shaffer, FLMI, ACS
Compliance Manager
Insurance Administrative Solutions, L.L.C.
8545 126th Avenue North, Suite 200
Largo, Florida 33773-1502

Re: Filing/Reporting Requirements

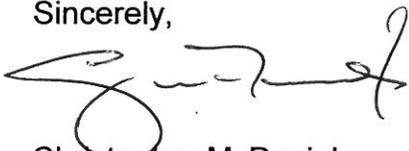
Dear Ms. Shaffer:

This letter authorizes Insurance Administrative Solutions, L.L.C. to file on behalf of Heartland National Life Insurance Company their policy forms, rate filings and reports with the State Departments of Insurance.

Insurance Administrative Solutions, L.L.C. may correspond with the State Departments of Insurance regarding any questions they may have concerning the filings.

A copy of this letter is as valid as the original. This authorization will be valid for twelve months from the date of this letter.

Sincerely,



Christopher McDaniel
CEO & President

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Form: HN-ATA

Incorrect, Misspelled or Blank Name EXAMPLE: Jane Smyth is changed to Jayne Smith
Incorrect, Misspelled or Blank Resident Address – EXAMPLE : Changed from 1st Street to 1st Avenue
Incorrect Telephone Number – EXAMPLE: Changed from 000-00-0000 to 123-45-7890
Incorrect, Misspelled or Blank City – EXAMPLE: Janesville is changed to Jonesville
Incorrect, Misspelled or Blank State – Residence State: EXAMPLE:YY is changed to XX
Incorrect or Blank Zip Code – Zip Code: EXAMPLE: 12345 is changed to 12346
Incorrect or Blank Date of Birth – EXAMPLE: Date of Birth: 08/08/19XX
Incorrect or Blank Current Age – EXAMPLE: Age is changed from 65 to 66
Incorrect or Blank Sex – SEX: Male
SEX: Female
Incorrect, Incomplete or Blank Social Security Number – EXAMPLE: Social Security Number: 123-45-1234
Incorrect, Incomplete or Blank Medicare Number – EXAMPLE: Medicare Claim Number: 123456780A
Incorrect, Incomplete or Blank - Height and Weight
Incorrect or Blank - Plan EXAMPLE: Plan A changed to PLAN D

Premium Payment

Incorrect Incomplete or Blank Requested Effective Date: EXAMPLE: 08/01/2009
Incorrect or Blank – Initial Bank Draft EXAMPLE: Issue Date changed to Effective Date
Incorrect or Blank Payment Mode: EXAMPLE: Annual changed to Semi-Annual premium
Incorrect or Blank: Bank Routing #; Bank Account #:
Incorrect or Blank: Bank Name;
Incorrect or Blank: Name(s) of Depositor(s)
Left Blank: Signature of Depositor

Eligibility Questions

Incomplete, incorrect or left blank

1. Have you used tobacco in any form in the past 12 months? ANSWER: Yes No

2. Are you covered under Medicare Part A? ANSWER: Yes No

If YES, what is your Part A effective date? EXAMPLE 08-15-2010

If NO, what is your eligibility date? EXAMPLE 08-15-2010

3. Are you covered under Medicare Part B? ANSWER: Yes No

If YES, what is your Part A effective date? EXAMPLE 08-15-2010

If NO, what is your eligibility date? EXAMPLE 08-15-2010

4. Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility).

ANSWER Yes No

Medicare & Insurance Information

Incorrect, Incomplete or Blank Replacement Information

Incorrect, Incomplete or left blank: Did you turn age 65 in the last 6 months? **ANSWER:** Yes No

Incorrect, Incomplete or left blank: Did you enroll in Medicare Part B in the last 6 months? **ANSWER:** Yes No

Incorrect, Incomplete or left blank: If yes, what is the effective date? **EXAMPLE:** 08/01/2000

2. Are you covered for medical assistance through the state Medicaid program? **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.

ANSWER Yes No

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy? **ANSWER** Yes No

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

ANSWER Yes No

3. Are you covered for medical assistance through the state Medicaid program? **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. **ANSWER** Yes No

If yes,

(b) Will Medicaid pay your premiums for this Medicare supplement policy? **ANSWER** Yes No

(c) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

ANSWER Yes No

4. Are you covered for medical assistance through the state Medicaid program? **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. **ANSWER** Yes No

If yes,

(c) Will Medicaid pay your premiums for this Medicare supplement policy? **ANSWER** Yes No

(d) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

ANSWER Yes No

5. 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), **ANSWER:** Yes No

(a) Name of Company **EXAMPLE** ABC Insurance

Plan Type & Policy/Certificate No. Left Blank **EXAMPLE:** Plan A Policy # 123456

Company telephone number Left Blank **EXAMPLE** (800) 789-1234

Coverage Dates Left Blank **EXAMPLE:** Start Date 05/11/2005 End Date 05/11/2011

(b) **If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?** **ANSWER:** Yes No

(c) Reason for termination/disenrollment? Left Blank

(d) Planned date of termination/disenrollment? Left Blank

(e) Was this your first time in this type of Medicare plan? **ANSWER:** Yes No

(f) Did you drop a Medicare supplement policy to enroll in the Medicare Plan?

ANSWER: Yes No

(g) Is your former Medicare Supplement or Medicare Select policy/certificate still available? **ANSWER:** Yes

No

6. Do you have another Medicare supplement policy in force? **ANSWER:** Yes No

(a) Name of company Left Blank **EXAMPLE: ABC Ins Co.**

Plan Type & Policy/Certificate No. Left Blank **EXAMPLE: Plan A**

Company Telephone Number Left Blank **EXAMPLE 333-333-3333**

Issue Date Left Blank **EXAMPLE: 03/31/2010**

(b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? **ANSWER:** Yes No

(c) Indicate termination date Left Blank **EXAMPLE: 03/31/2010**

7. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) **ANSWER:** Yes No

(a) Name of company Left Blank **Example: ABC Ins Co.**

Plan Type & Certificate/ Policy Number Left Blank **Example: MedSup/Policy, Certificate# 123456**

Company telephone number Left Blank **EXAMPLE: (800) 123-4567**

Coverage Dates: Left Blank **EXAMPLE Date started 08/01-1998 - Dated ended 07/31/2011**

(b) Reason for termination/disenrollment? Left Blank

(c) Planned date of termination/disenrollment? Left Blank **EXAMPLE 05/11/2011**

Health Questions - This Section is not completed if the applicant is applying during an open enrollment or guaranteed issue period.

Incomplete, incorrect or left blank

1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? **ANSWER Yes** **No**

2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? **ANSWER Yes** **No**

3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis? **ANSWER Yes** **No**

4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder? **ANSWER Yes** **No**

5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **ANSWER Yes** **No**

6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), or kidney disease? If you do **not** have diabetes, this question should be answered "NO." **ANSWER Yes** **No**

7. Do you have diabetes that has ever required more than 50 units of insulin daily? **ANSWER Yes** **No**

8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? **ANSWER Yes** **No**

9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? **ANSWER Yes** **No**

10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? **ANSWER Yes** **No**

11. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts? **ANSWER Yes** **No**

12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? **ANSWER Yes** **No**

13. Have you been hospital confined three or more times in the last two years? **ANSWER Yes** **No**

14. Have you had an organ transplant or been advised by a physician to have an organ transplant?

ANSWER Yes **No**

15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months?

ANSWER: Yes **No**

Incomplete, incorrect or left blank

If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

EXAMPLE

Medication Name: Zestril

Date Originally Prescribed: October 2006

Dosage and Frequency: 10 mg, once daily

Diagnosis/Condition: High Blood Pressure

Authorization and Certification Signature and/or date left blank