

SERFF Tracking Number: ANTX-126515349 State: Arkansas  
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 45265  
 Company Tracking Number:  
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010  
 Product Name: 2010 MEDICARE SUPPLEMENT  
 Project Name/Number: 2010 MEDICARE SUPPLEMENT/2010 MEDICARE SUPPLEMENT

## Filing at a Glance

Company: Standard Life and Accident Insurance Company  
 Product Name: 2010 MEDICARE SUPPLEMENT SERFF Tr Num: ANTX-126515349 State: Arkansas  
 TOI: MS09 Medicare Supplement - Other 2010 SERFF Status: Closed-Approved-Closed State Tr Num: 45265  
 Sub-TOI: MS09.000 Medicare Supplement Other 2010 Co Tr Num: State Status: Approved-Closed  
 Filing Type: Form/Rate Reviewer(s): Stephanie Fowler  
 Author: Sherry Wiegman Disposition Date: 04/19/2010  
 Date Submitted: 03/25/2010 Disposition Status: Approved-Closed  
 Implementation Date Requested: On Approval Implementation Date: 06/01/2010  
 State Filing Description:

## General Information

Project Name: 2010 MEDICARE SUPPLEMENT Status of Filing in Domicile: Pending  
 Project Number: 2010 MEDICARE SUPPLEMENT 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: 04/19/2010 Explanation for Other Group Market Type:  
 State Status Changed: 04/19/2010  
 Deemer Date: Created By: Sherry Wiegman  
 Submitted By: Sherry Wiegman Corresponding Filing Tracking Number:  
 Filing Description:  
 Attached for your review and consideration are new Medicare Supplement forms and rate information. This filing represents our 2010 Medicare Supplement products that will be available as of June 1, 2010. This is a new submission that has not been previously reviewed or rejected.

We anticipate marketing plans A, B, C, D, F, F(hd), G and N through licensed agents. The policy will be issued with the chosen plan endorsement.

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The application(s) will be completed by an individual applicant either in person or electronically or through a telephone process.

Underwriting will be applied to applicants outside of the open enrollment or guarantee issue periods.

Applicable smoker or non-smoker rates will be applied to all applicants at all times.

Actuarial information and the brochure is also included for your review and approval.

We trust this information is complete and look forward to receiving your favorable reply. Thank you for your consideration.

## Company and Contact

### Filing Contact Information

Sherry Wiegman, Sr. Compliance Analyst sherry.wiegman@anico.com  
 One Moody Plaza, SSH MP, Ste. 200 281-538-4842 [Phone]  
 Galveston, TX 77550 409-766-2950 [FAX]

### Filing Company Information

Standard Life and Accident Insurance Company CoCode: 86355 State of Domicile: Texas  
 One Moody Plaza, SSH MP, Ste. 200 Group Code: 408 Company Type: Health Insurance  
 Galveston, TX 77550 Group Name: State ID Number:  
 (281) 538-4842 ext. [Phone] FEIN Number: 73-0994234

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$800.00  
 Retaliatory? Yes  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Life and Accident Insurance Company	\$800.00	03/25/2010	35173486

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	04/19/2010	04/19/2010

### 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	04/09/2010	04/09/2010	Sherry Wiegman	04/16/2010	04/16/2010

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Rates by Monthly Premium	Sherry Wiegman	04/19/2010	04/19/2010

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Rates	Note To Filer	Stephanie Fowler	04/19/2010	04/19/2010

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## Disposition

Disposition Date: 04/19/2010

Implementation Date: 06/01/2010

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.

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Standard Life and Accident Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

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Schedule	Schedule Item	Schedule Item Status	Public Access
<b>Supporting Document</b>	Flesch Certification	Accepted for	Yes
		Informational Purposes	
<b>Supporting Document</b>	Application	Approved	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved	No
<b>Supporting Document</b>	Outline of Coverage	Approved	Yes
<b>Supporting Document</b>	PREVIOUSLY APPROVED REPLACEMENT NOTICE	Accepted for	Yes
		Informational Purposes	
<b>Supporting Document</b>	Rates by Monthly Premium	Approved	Yes
<b>Form</b>	Policy	Approved	Yes
<b>Form</b>	Outline of Coverage	Approved	Yes
<b>Form</b>	Paper & Telephone Application	Approved	Yes
<b>Form</b>	Electronic Application	Approved	Yes
<b>Form</b>	Brochure	Approved	Yes
<b>Form</b>	Plan A Endorsement	Approved	Yes
<b>Form</b>	Plan B Endorsement	Approved	Yes
<b>Form</b>	Plan C Endorsement	Approved	Yes
<b>Form</b>	Plan D Endorsement	Approved	Yes
<b>Form</b>	Plan F Endorsement	Approved	Yes
<b>Form</b>	Plan FHD Endorsement	Approved	Yes
<b>Form</b>	Plan G Endorsement	Approved	Yes
<b>Form</b>	Plan N Endorsement	Approved	Yes
<b>Rate</b>	2010 Medicare Supplement Product	Approved	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 04/09/2010  
Submitted Date 04/09/2010  
Respond By Date 05/10/2010

Dear Sherry Wiegman,

This will acknowledge receipt of the captioned filing.

### Objection 1

- 2010 Medicare Supplement Product, [2010-1006-AR] (Rate)

Comment: This filing is currently under review. However, I will need a copy of the proposed base monthly rates by dollar amount to complete my review.

Thank you in advance for your consideration in this matter.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 04/16/2010  
Submitted Date 04/16/2010

Dear Stephanie Fowler,

### Comments:

We have completed the review of your request for information relating to the premium rates.

### Response 1

Comments: Our actuary, Michael Shumate, has advised that our base rate is annual and that the monthly rate can be derived by multiplying by 0.0875.

I have included a copy of the rate pages for your review.

### Related Objection 1

Applies To:

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Project Name/Number: 2010 MEDICARE SUPPLEMENT/2010 MEDICARE SUPPLEMENT  
- 2010 Medicare Supplement Product, [2010-1006-AR] (Rate)

**Comment:**

This filing is currently under review. However, I will need a copy of the proposed base monthly rates by dollar amount to complete my review.

Thank you in advance for your consideration in this matter.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thanking you in advance for your further consideration.

Sincerely,  
Sherry Wiegman

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**Amendment Letter**

Submitted Date: 04/19/2010

**Comments:**

We have reviewed your Filer's note. Attached is our monthly premiums as requested.

Please advise if additional information is needed. Thank you for your continued review.

**Changed Items:**

**Supporting Document Schedule Item Changes:**

**User Added -Name: Rates by Monthly Premium**

Comment:

AR Rates by Monthly Premium.pdf

AR Actuarial Memorandum w Rates.pdf

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**Note To Filer**

**Created By:**

Stephanie Fowler on 04/19/2010 10:30 AM

**Last Edited By:**

Stephanie Fowler

**Submitted On:**

04/19/2010 01:08 PM

**Subject:**

Rates

**Comments:**

It does not appear that the rates were attached to your response. Also, I would like to clarify that I need these rates calculated down to the monthly premium.

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## Form Schedule

### Lead Form Number: 2010-1006

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 04/19/2010	2010-1006-AR	Policy/Cont	Policy ract/Fratern al Certificate	Initial		50.100	AR SLAICO 2010 Policy.pdf
Approved 04/19/2010	MSOC10A R	Outline of Coverage	Outline of Coverage	Initial		50.100	AR Outline.pdf
Approved 04/19/2010	MSAPP10A R	Application/ Enrollment Form	Paper & Telephone Application	Initial		50.100	AR Application.pdf
Approved 04/19/2010	MSAPP10A R-E	Application/ Enrollment Form	Electronic Application	Initial		50.100	AR APPLICATION ELECTRONI C.pdf
Approved 04/19/2010	MSB10	Advertising Brochure		Initial		50.100	BROCHURE MSB10 3-7- 2010.pdf
Approved 04/19/2010	2010-1006-A	Policy/Cont	Plan A Endorsement ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50.100	SLAICO 2010 PLan A Endorsement. pdf
Approved 04/19/2010	2010-1006-B	Policy/Cont	Plan B Endorsement ract/Fratern al Certificate: Amendmen	Initial		50.100	SLAICO 2010 Plan B Endorsement. pdf

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<i>Project Name/Number:</i>	2010 MEDICARE SUPPLEMENT/2010 MEDICARE SUPPLEMENT		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved 2010-1006- 04/19/2010 C	Policy/Cont Plan C Endorsement Initial ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	50.100	SLAICO 2010 Plan C Endorsement. pdf
Approved 2010-1006- 04/19/2010 D	Policy/Cont Plan D Endorsement Initial ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	50.100	SLAICO 2010 Plan D Endorsement. pdf
Approved 2010-1006- 04/19/2010 F	Policy/Cont Plan F Endorsement Initial ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	50.100	SLAICO 2010 Plan F Endorsement. pdf
Approved 2010-1006- 04/19/2010 FHD	Policy/Cont Plan FHD ract/Fratern Endorsement al Certificate: Amendmen t, Insert Page,	Initial 50.100	SLAICO 2010 Plan F(HD) Endorsement. pdf

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<i>Project Name/Number:</i>	2010 MEDICARE SUPPLEMENT/2010 MEDICARE SUPPLEMENT		
	Endorseme nt or Rider		
Approved 2010-1006- 04/19/2010 G	Policy/Cont Plan G Endorsement Initial ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	50.100	SLAICO 2010 Plan G Endorsement. pdf
Approved 2010-1006- 04/19/2010 N	Policy/Cont Plan N Endorsement Initial ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	50.100	SLAICO 2010 PLan N Endorsement. pdf

**Standard Life and Accident Insurance Company**  
A Member of the American National Family of Companies  
Administrative Office: [P. O. Box 1820, Galveston Texas 77550]  
Toll-Free Telephone Number: [1-888-350-1488]

(A Stock Company hereafter referred to as "Standard Life", "We", "Us", "Our" or "the Company")

## MEDICARE SUPPLEMENT POLICY

**This Policy, in accordance with its terms, provides benefits which supplement Medicare. It is guaranteed renewable. Premiums are subject to change each year.**

INSURED **JOHN DOE**

POLICY NUMBER **999999999**

**The DATA AND SCHEDULE PAGE for this Policy is found on Page 3.**

This Policy is designed to supplement certain benefits provided by Medicare. Medicare is the Health Insurance for The Aged Act set forth in Title XVIII of the United States Social Security Act Amendments of 1965 as then constituted or as later amended. **Please read the Benefits Provision and the Endorsement carefully.**

**BENEFIT ADJUSTMENT.** The benefits of this Policy change when Medicare benefits change. This Policy will continue to supplement Medicare in the same manner after the change as it did before the change. When benefit changes occur Your premium may change.

**CONSIDERATION - EFFECTIVE DATE.** This Policy is issued in consideration of the application and payment of the Initial Premium. It takes effect on the Date of Issue. The application is a part of this Policy. The Insured is referred to as "You" in this Policy. The Initial Premium, the Date of Issue and the Insured are shown on the Data and Schedule Page. This is a Non-Participating Policy. This Policy is a legal contract between the Insured and Standard Life.

**PREMIUM DUE DATE.** The Initial Premium is for the Initial Term shown on the Data and Schedule Page. The renewal premium for later Policy terms is due on the first day of the next term. This Policy will end (lapse) if the renewal premium in effect is not paid when due or within the grace period.

**30 DAY RIGHT TO EXAMINE POLICY.** Within 30 days after You get this Policy, if for any reason You decide You do not want it, You may return it to Us. You may also return it to Our agency office or the agent who sold it to You. We will refund Your premium to You. Then You and We will be in the same position as if a Policy had never been issued.

**RENEWAL CONDITIONS** You may keep this Policy in force for as long as You live, if You pay the premiums as they become due or within the grace period.

**GUARANTEED RENEWABLE – THE PREMIUMS MAY CHANGE.** Your Policy was issued on a Community Rated basis and Your premium will not increase each year due to the increase in Your age. We may change the premiums for Your Policy if We change the premium for all policies like yours in Your state on a class basis or when benefit changes occur. Any change will apply to future premiums only. **We will give You written notice 60 days prior to any premium change.**

## **THIS POLICY IS A LEGAL CONTRACT - PLEASE READ IT CAREFULLY!**

This Policy is signed below in behalf of Standard Life and Accident Insurance Company by its duly authorized officers.



Secretary



President

\_\_\_\_\_  
Countersignature of Licensed Agent  
(where required)

**NOTICE TO BUYER:** This Policy may not cover all of your medical expenses

**WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application is guilty of a crime and may be subject to fines and confinement in prison.

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## IMPORTANT NOTICE

### **PLEASE READ YOUR POLICY AND THE COPY OF THE APPLICATION CAREFULLY.**

Omissions or errors in the application may cause Us to deny Your claim or to rescind Your Policy. Errors may cause a delay in payment of Your claim.

If You find incorrect or incomplete information, or any medical history that You have not included, write to Our Underwriting Department within thirty (30) days of Your receipt of this Policy.

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

DATA AND SCHEDULE PAGE

**NOTICE:** THE DEDUCTIBLES AND BENEFIT AMOUNTS WILL CHANGE IN ACCORDANCE WITH FEDERAL REQUIREMENTS.

**PLAN OPTION [A][B][C][D][F][F(hd)][G][N]: PLEASE REFER TO THE ATTACHED PLAN OPTION ENDORSEMENT FOR ADDITIONAL INFORMATION.**

**[YOUR ANNUAL POLICY DEDUCTIBLE FOR 2010 IS [\$2,000]. ]**

INSURED:	[JOHN DOE]	DATE OF ISSUE:	[06/01/2010]
POLICY NUMBER:	[999999999]	AGE AT ISSUE:	[72]
PREMIUM CLASS:	[NON-TOBACCO USER]	GENDER:	[MALE]
STATE OF ISSUE:	ARKANSAS	RATE METHOD:	COMMUNITY RATED
INITIAL PREMIUM:	[\$ 300.00]	ANNUAL PREMIUM:	[\$ 1,999.99]
INITIAL TERM:	[MONTHLY]	POLICY FORM:	2010-1006-AR

[INTENTIONALLY LEFT BLANK]

## SECTION ONE - TERMS YOU SHOULD KNOW

**Benefit Period** is a period of time which begins with Your first full day in a hospital. It ends when You have not been in the hospital for 60 consecutive days.

**Calendar Year** means a 12 month period that starts on each January 1st and ends December 31<sup>st</sup>.

**Coinsurance Amount** means the portion of Medicare Eligible Expenses, other than any Medicare deductible, that You must pay.

**Hospice** means a Medicare approved hospice program that provides a formal program of care that is:

1. For terminally ill patients whose life expectancy is less than six (6) months;
2. Provided in Your home or other Medicare approved setting; and
3. Directed by a physician.

**Hospital** means an institution licensed as a hospital and operated pursuant to law.

**Injury** means accidental bodily injury sustained while this Policy is in force.

**Lifetime Reserve Days** are the 60 day inpatient lifetime reserve You have under Part A of Medicare.

**Medicaid** means Grants to States for Medical Assistance Programs, Title XIX of the United States Social Security Act Amendments of 1965 as then constituted or later amended.

**Medicare Eligible Expenses** means expenses of the kind covered by Medicare to the extent recognized as reasonable and medically necessary by Medicare. If You are not covered under Part B of Medicare, Standard Life will determine Part B Medicare Eligible Expenses and what Medicare would have paid as if You were covered under Part B of Medicare.

**Part A Deductible** means the Benefit Period inpatient Hospital deductible under Part A of Medicare.

**Part B Deductible** means the calendar year medical deductible under Part B of Medicare.

**Physician** means a practitioner of the healing arts who is licensed by the state to treat the type of injury or sickness for which claim is made.

**Respite Care** means a Medicare approved facility that provides temporary or periodic care so that a family member or friend who is Your caregiver can rest or take some time off.

**Sickness** means illness or disease which first manifests itself after the effective date of insurance and while the Policy is in force.

**We, Us or Our** means Standard Life and Accident Insurance Company.

**You or Your** means the person insured by Us and shown as Insured on the Data and Schedule Page and on the first page of this Policy.

## SECTION TWO - BENEFITS

This section tells how We will pay benefits under the Policy. In order for Us to pay any benefits, Medicare Eligible Expenses must be provided for You while coverage under the Policy is in force.

**WHAT WE PAY** - Benefits are payable under the Policy in accordance with the Plan Option You have selected in Your Application and is described in the attached "Plan Option" endorsement.

**BENEFIT ADJUSTMENT** - The benefits of the Policy change when Medicare benefits change. The Policy will continue to supplement Medicare in the same manner after the change as it did before the change. When benefit changes occur Your premium may change.

## SECTION THREE - EXCEPTIONS

This Policy does not contain: 1) benefits which duplicate benefits provided by Medicare; or 2) limitations or exclusions on coverage that are more restrictive than those of Medicare. Benefits will not be paid under this Policy for any type of item or service not eligible for coverage under Medicare.

## SECTION FOUR - CLAIMS

**NOTICE OF CLAIMS.** You must give Us written notice of a claim. It should be given within 60 days after a covered loss, or as soon as possible. You may do it or have someone do it for You. It should give Your name and Policy number. It should be mailed to Us or any of its agents. Notice given by You or on Your behalf to Us at Our Home Office, or to any authorized agent with information sufficient to identify You, will be deemed notice to Us.

**CLAIM FORMS.** We will send a claim form to You when Your notice of claim is received. If You do not receive it within 15 days from the time You give notice, You may fulfill the proof of loss requirements by sending written proof relating to Your claim to Us within the time set in the Proof of Loss provision.

**PROOF OF LOSS.** You should give Us written proof of loss within 90 days after the loss. If it is not reasonably possible to give proof in 90 days, We will not reduce or deny Your claim for being late if proof is given as soon as reasonably possible. It must, however, be given within 15 months unless You are not legally capable.

**TIME OF PAYMENT OF CLAIMS.** All benefits due under this Policy will be paid as soon as proof of loss is received.

**PAYMENT OF CLAIMS.** All benefits due under this Policy will be paid to You or Your estate, unless otherwise assigned. If they are payable to Your estate, We may pay up to \$1,000 to any relative of yours it finds is entitled to the benefits. Payment made in good faith will discharge Us to the extent of the payment. Any benefits remaining after making such payment will then be paid to Your estate. If We receive notice that services are received under Medicaid, then any and all benefits payable for such services will be made to the appropriate entity that administers the program in Your state.

**PHYSICAL EXAMINATIONS AND AUTOPSY.** We will have, at Our expense, the right and opportunity to examine You when and as often as it may reasonably require during the pendency of a claim made under this Policy and to make an autopsy in case of death where it is not forbidden by law.

**LEGAL ACTIONS.** You cannot bring legal action to recover under this Policy for at least 60 days after You have given Us written proof of loss. You cannot start such action more than 3 years after the date proof of loss is required to be given.

## SECTION FIVE - ABOUT YOUR POLICY

**ENTIRE CONTRACT, CHANGES.** This Policy, with the application, endorsements and any attached papers, is the entire contract of insurance. No agent may change it in any way. We will deem all statements, except fraudulent statements, that You make as representations and not warranties. Only an executive officer of Standard Life can approve a change. Any such change must be attached to this Policy.

**TIME LIMIT ON CERTAIN DEFENSES.** We will not void this Policy or deny a claim for an expense incurred after 2 years from the Date of Issue because of misstatements, other than fraudulent ones, You made in the application.

**TIME PERIODS.** Each Policy term will begin and end at 12:01 A.M. in the state where You live.

**MISSTATEMENT OF AGE.** If Your age has been misstated, the amounts payable under this Policy are the amounts the premium paid would have purchased at the correct age.

**UNPAID PREMIUM.** Any due and unpaid premium for this Policy may be deducted from its benefits then payable.

**PREMIUM REFUND AT DEATH.** If this Policy is in force when You die, coverage will end and the pro rata unearned portion of any premium paid will be refunded. Unearned premiums will be paid in lump sum no later than thirty (30) days after We receive proof of Your death.

**GRACE PERIOD** There will be a grace period for payment of each renewal premium. It will be 31 days from the date the premium is due. This Policy will stay in force during the 31 days. If the premium is not paid before the Grace Period ends, this Policy will lapse.

**REINSTATEMENT.** Once this Policy has lapsed, it may be reinstated, but only with Our approval. We will not consider a request for reinstatement that you make more than 180 days after your Policy has lapsed. This Policy will be automatically reinstated if We or any agent authorized by Us to accept premium accepts a renewal premium for this Policy within 30 days after the Grace Period ends. After such time, an application will be required and You will be given a conditional receipt for the premium You pay. We will notify You of Our approval or disapproval of Your application. Without such notice, Your Policy will be considered reinstated on the 45th day from the date of the conditional receipt. A reinstated Policy will cover only injuries or sicknesses that occur after the date of reinstatement. In all other respects You and the Company will have the same rights as each had immediately before the due date of the premium that was not paid.

**CONFORMITY WITH STATE STATUTES.** Any Policy provision which, on the Date of Issue, is in conflict with the laws of the state where You then live is automatically amended to conform to the minimum requirements of those laws.

## **SECTION SIX - SUSPENSION OF BENEFITS**

The benefits and premiums under this Policy will be suspended at Your request for the period of 24 months in which You have applied for and are determined to be entitled to medical assistance under Medicaid (as defined in Title XIX of the Social Security Act - 42 U.S.C.A. §§ 1396—1396u). You must notify Us within 90 days after the date You become entitled to this assistance. If a suspension occurs and You lose entitlement to Medicaid, Your Policy will be automatically reinstated (effective as of the date of termination of the entitlement) if You provide notice of loss of the entitlement within 90 days after the date of loss of entitlement and pay the required premium, effective as of the date of termination of the entitlement.

The benefits and premiums under this Policy will be suspended (for any period provided by federal regulation) at Your request if You are under 65 years of age and entitled to benefits under Medicare (as defined in Section 226(b) of the Social Security Act – 42 U.S.C.A. § 426(b)) and are covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act – 42 U.S.C.A. § 1395y(b)(ii)(A)(v)). If a suspension occurs and You lose coverage under the group health plan, the Policy will be automatically reinstated (effective as of the date of loss of coverage) if You provide notice of loss of coverage within 90 days after the date of the loss and pay the premium attributable to the period, effective as of the date of termination of the group health plan.

Your coverage under the reinstated Policy:

1. May not provide for a waiting period with respect to treatment of pre-existing conditions;
2. Will provide for coverage which is substantially equivalent to coverage in effect before the date of the suspension; and
3. Will provide for classification of premiums on terms at least as favorable to You as the premium classification terms that would have applied to You if the coverage had not been suspended.



**Standard Life and Accident Insurance Company**

P.O. Box 696820  
San Antonio, TX 78269  
888.350.1488

**Outline of Medicare Supplement Coverage**

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

**2010**

**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	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 \$[4,620]; paid at 100% after limit reached	Out-of-pocket limit \$[2,310]; paid at 100% after limit reached		
<b>Policy Form 2010-1006 Plan A</b>	<b>Policy Form 2010-1006 Plan B</b>	<b>Policy Form 2010-1006 Plan C</b>	<b>Policy Form 2010-1006 Plan D</b>	<b>Policy Form 2010-1006 Plan F</b>	<b>Policy Form 2010-1006 Plan F(HD)</b>	<b>Policy Form 2010-1006 Plan G</b>				<b>Policy Form 2010-1006 Plan N</b>

\*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.

**ARKANSAS PREMIUMS FOR ZIP CODES (727, 729)**

<b>2010</b>		<b>PLAN A RATES</b>							<b>2010</b>
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>				
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	
65 and Older	[\$2,258.81]	[\$1,174.58]	[\$609.88]	[\$197.65]	[\$2,509.79]	[\$1,305.09]	[\$677.64]	[\$219.61]	

<b>PLAN B RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,571.84]	[\$1,1337.36]	[\$694.40]	[\$225.04]	[\$2,857.60]	[\$1,485.95]	[\$771.55]	[\$250.04]

<b>PLAN C RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,923.98]	[\$1,520.47]	[\$789.47]	[\$255.85]	[\$3,248.87]	[\$1,689.41]	[\$877.19]	[\$284.28]

<b>PLAN D RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,761.89]	[\$916.18]	[\$475.71]	[\$154.17]	[\$1,957.65]	[\$1,017.98]	[\$528.57]	[\$171.29]

<b>PLAN F RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,404.52]	[\$1,250.35]	[\$649.22]	[\$210.40]	[\$2,671.69]	[\$1,389.28]	[\$721.36]	[\$233.77]

<b>PLAN F (HIGH DEDUCTIBLE) RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$349.65]	[\$181.82]	[\$94.41]	[\$30.59]	[\$388.49]	[\$202.01]	[\$104.89]	[\$33.99]

<b>PLAN G RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,775.34]	[\$923.18]	[\$479.34]	[\$155.34]	[\$1,972.60]	[\$1,025.75]	[\$532.60]	[\$172.60]

<b>PLAN N RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,159.69]	[\$603.04]	[\$313.12]	[\$101.47]	[\$1,288.54]	[\$670.04]	[\$347.91]	[\$112.75]

**ARKANSAS PREMIUMS FOR ZIP CODES (716-717, 719-722, 724-726, 728)**

<b>2010</b>		<b>PLAN A RATES</b>							<b>2010</b>
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>				
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	
65 and Older	[\$2,524.55]	[\$1,312.77]	[\$681.63]	[\$220.90]	[\$2,805.06]	[\$1,458.63]	[\$757.37]	[\$245.44]	

<b>PLAN B RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,874.41]	[\$1,494.69]	[\$776.09]	[\$251.51]	[\$3,193.79]	[\$1,660.77]	[\$862.32]	[\$279.46]

<b>PLAN C RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$3,267.98]	[\$1,699.35]	[\$882.35]	[\$285.95]	[\$3,631.09]	[\$1,888.17]	[\$980.36]	[\$317.72]

<b>PLAN D RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,969.17]	[\$1,023.97]	[\$531.68]	[\$172.30]	[\$2,187.96]	[\$1,137.74]	[\$590.75]	[\$191.45]

<b>PLAN F RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,687.41]	[\$1,397.45]	[\$725.60]	[\$235.15]	[\$2,986.01]	[\$1,552.73]	[\$806.22]	[\$261.28]

<b>PLAN F (HIGH DEDUCTIBLE) RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$390.78]	[\$203.21]	[\$105.51]	[\$34.19]	[\$434.20]	[\$225.78]	[\$117.23]	[\$37.99]

<b>PLAN G RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,984.20]	[\$1,031.78]	[\$535.73]	[\$173.62]	[\$2,204.67]	[\$1,146.43]	[\$595.26]	[\$192.91]

<b>PLAN N RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,296.12]	[\$673.98]	[\$349.95]	[\$113.41]	[\$1,440.13]	[\$748.87]	[\$388.84]	[\$126.01]

**ARKANSAS PREMIUMS FOR ZIP CODES (718, 723)**

<b>2010</b>		<b>PLAN A RATES</b>							<b>2010</b>
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>				
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	
65 and Older	[\$2,790.29]	[\$1,450.95]	[\$753.98]	[\$244.15]	[\$3,100.32]	[\$1,612.17]	[\$837.09]	[\$271.28]	

<b>PLAN B RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$3,176.97]	[\$1,652.02]	[\$857.78]	[\$277.98]	[\$3,529.97]	[\$1,835.58]	[\$953.09]	[\$308.87]

<b>PLAN C RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$3,611.98]	[\$1,878.23]	[\$975.23]	[\$316.05]	[\$4,013.31]	[\$2,086.92]	[\$1,083.59]	[\$351.16]

<b>PLAN D RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,176.45]	[\$1,137.75]	[\$587.64]	[\$190.44]	[\$2,418.28]	[\$1,257.51]	[\$652.94]	[\$211.60]

<b>PLAN F RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,970.29]	[\$1,544.55]	[\$801.98]	[\$259.90]	[\$3,300.33]	[\$1,716.17]	[\$891.09]	[\$288.78]

<b>PLAN F (HIGH DEDUCTIBLE) RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$431.92]	[\$224.60]	[\$116.62]	[\$37.79]	[\$479.90]	[\$249.55]	[\$129.57]	[\$41.99]

<b>PLAN G RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,193.06]	[\$1,140.39]	[\$592.13]	[\$191.89]	[\$2,436.74]	[\$1,267.10]	[\$657.92]	[\$213.21]

<b>PLAN N RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,432.56]	[\$744.93]	[\$386.79]	[\$125.35]	[\$1,591.73]	[\$827.70]	[\$429.77]	[\$139.28]

## **PREMIUM INFORMATION**

We, Standard Life and Accident Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state.

## **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 your insurance company.

## **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to:

Standard Life and Accident  
Insurance Company  
P.O. Box 696820  
San Antonio, TX 78269

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 Standard Life 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. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

**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.

<b>PLAN A</b>			
<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	\$0 [\$275] a day [\$550] a day 100% of Medicare Eligible Expenses \$0	[\$1,100] (Part A Deductible) \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$137.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs inpatient respite care	Medicare copayment/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 an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**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.

**PLAN A**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> 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
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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
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**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.

**PLAN B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days  61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days  — Beyond the Additional 365 days	All but [\$1,100]  All but [\$275] a day  All but [\$550] a day  \$0  \$0	[\$1,100] (Part A Deductible)  [\$275] a day  [\$550] a day  100% of Medicare Eligible Expenses  \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$137.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

**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.

**PLAN B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> 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
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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
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**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.

**PLAN C**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 Up to [\$137.50] a day \$0	\$0 \$0 All costs

**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.

**PLAN C**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES —</b> 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%	[\$155] (Part B Deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next [\$155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs [\$155] (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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 [\$155] (Part B Deductible) 20%	\$0 \$0 \$0
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**OTHER BENEFITS — NOT COVERED BY MEDICARE**

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

**PLAN D**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 Up to [\$137.50] a day \$0	\$0 \$0 All costs

**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.

**PLAN D**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> 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
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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
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## OTHER BENEFITS — NOT COVERED BY MEDICARE

## PLAN D

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

**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.

**PLAN F**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 Up to [\$137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs inpatient respite care	Medicare copayment/coinsurance	\$0

**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.

**PLAN F**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES —</b> 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%	[\$155] (Part B Deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs [\$155] (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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 [\$155] (Part B Deductible) 20%	\$0 \$0 \$0
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**OTHER BENEFITS — NOT COVERED BY MEDICARE**

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

† This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.

**PLAN F (HIGH DEDUCTIBLE)**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2,000] DEDUCTIBLE† PLAN PAYS	IN ADDITION TO [\$2,000] DEDUCTIBLE† YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies:</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> <li>— While using 60 lifetime reserve days</li> <li>— Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>— Additional 365 days</li> <li>— Beyond the Additional 365 days</li> </ul> </li> </ul>	<p>All but [\$1,100]</p> <p>All but [\$275] a day</p> <p>All but [\$550] a day</p> <p>\$0</p> <p>\$0</p>	<p>[\$1,100] (Part A Deductible)</p> <p>[\$275] a day</p> <p>[\$550] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>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>Up to [\$137.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b></p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>

**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.

† This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

**PLAN F (HIGH DEDUCTIBLE)**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY [\$2,000] DEDUCTIBLE† PLAN PAYS</b>	<b>IN ADDITION TO [\$2,000] DEDUCTIBLE† YOU PAY</b>
<b>MEDICAL EXPENSES —</b> 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%	[\$155] (Part B Deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs [\$155] (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**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.

† This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.

**PARTS A & B**

**PLAN F (HIGH DEDUCTIBLE)**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2,000] DEDUCTIBLE† PLAN PAYS	IN ADDITION TO [\$2,000] DEDUCTIBLE† YOU PAY
<b>HOME HEALTH CARE</b> 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 BENEFITS — NOT COVERED BY MEDICARE**

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

**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.

**PLAN G**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days  61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days  — Beyond the Additional 365 days	All but [\$1,100]  All but [\$275] a day  All but [\$550] a day  \$0  \$0	[\$1,100] (Part A Deductible)  [\$275] a day  [\$550] a day  100% of Medicare Eligible Expenses  \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 Up to [\$137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

**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.

**PLAN G**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> 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%	\$0 \$0 [\$155] (Part B Deductible)
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$0 \$0 [\$155] (Part B Deductible)
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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 \$0 \$0 [\$155] (Part B Deductible)
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## OTHER BENEFITS — NOT COVERED BY MEDICARE

## PLAN G

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

**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.

**PLAN N**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days  61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days  — Beyond the Additional 365 days	All but [\$1,100]  All but [\$275] a day  All but [\$550] a day  \$0  \$0	[\$1,100] (Part A Deductible)  [\$275] a day  [\$550] a day  100% of Medicare Eligible Expenses  \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 Up to [\$137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs inpatient respite care	Medicare copayment/coinsurance	\$0

**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.

**PLAN N**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES —</b> 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 Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment 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.	[\$155] (Part B Deductible) Up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment 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.
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**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.

**PARTS A & B**

**PLAN N**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b>			
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**

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

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**APPLICATION FOR MEDICARE SUPPLEMENT** *(Please Print - Black Ink)*

**SECTION A**

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

**SECTION B**

- New Policy  Reinstatement
3. **I AM APPLYING FOR:** Medicare Supplement Plan \_\_\_\_\_  
 Male  Female
4. **Payment Mode:**  Annual  Semi-Annual  Quarterly  Monthly PAC
5. **Requested Effective Date:** \_\_\_\_\_
6. **Medicare claim number:** \_\_\_\_\_

**SECTION C**

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

**PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X".**

**To the best of your knowledge:**

7. Did you turn age 65 in the last 6 months?  
 Yes  No
8. Did you enroll in Medicare Part B in the last 6 months?  
 Yes  No  
 If Yes, what is the effective date? \_\_\_\_\_
9. 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.)  
 Yes  No  
 If Yes, will Medicaid pay your premiums for this Medicare Supplement policy?  
 Yes  No  
 If Yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?  
 Yes  No
10. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in

your start and end dates below. If you are still covered under this plan, leave "END" blank.

START \_\_\_\_/\_\_\_\_/\_\_\_\_ END \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Was this your first time in this type of Medicare plan?

Yes  No

Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

Yes  No

11. Do you have another Medicare Supplement policy in force?

Yes  No

If so, with what company, and what plan do you have?

\_\_\_\_\_  
 If so, do you intend to replace your current Medicare Supplement policy with this policy?

Yes  No

**SECTION C (continued)**

12. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan)

- Yes  No

If so, with what company and what kind of policy?

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

START \_\_\_\_/\_\_\_\_/\_\_\_\_ END \_\_\_\_/\_\_\_\_/\_\_\_\_

13. Do you qualify for open enrollment?

- Yes  No

If Yes, please explain.

14. Do you qualify for guarantee issue?

- Yes  No

If Yes, please submit proof with application.

**SECTION D**

**COMPLETE IF APPLYING FOR MEDICARE SUPPLEMENT ON A NON-OPEN ENROLLMENT OR NON-GUARANTEE ISSUE BASIS.**

Non Tobacco User  Tobacco User

Height \_\_\_\_\_ Weight \_\_\_\_\_

**UNDER OPEN ENROLLMENT, HEALTH QUESTIONS ARE NOT REQUIRED TO BE ANSWERED.**

**If the answer to any question in Section D (15-18h) is Yes, the application should not be submitted.**

15. Are you now bedridden, confined to a nursing home, assisted living facility or hospital, or receiving the services of a home health care agency?

- Yes  No

16. Within the past **10 years**, have you been treated for or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection?

- Yes  No

17. Within the past **2 years**, have you:

a) had or been recommended to have medical tests or treatment or surgery which have not been done or for which results have not been given?

- Yes  No

b) been hospitalized 2 or more times or confined to a nursing home or required assistance or supervision by another person for dressing, eating, personal hygiene (bathing or toileting), walking or transferring to or from a bed or chair or suffered a fracture of the spine or hip?

- Yes  No

c) required the use of a wheelchair, walker or cane?

- Yes  No

d) been advised to have cataract surgery or other eye surgery that has not been performed?

- Yes  No

18. Do you now have or within the past **2 years** have you had or been advised to have treatment, surgery or to take prescription medication for:

a) cancer (excluding basal or squamous cell), Hodgkin's disease, leukemia, or melanoma; even if the conditions are in remission?

- Yes  No

b) congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder, heart disease, enlarged heart, transient ischemic attack, stroke, heart or heart valve surgery, angioplasty, pacemaker, or stent placement?

- Yes  No

c) uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene?

- Yes  No

d) emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen?

- Yes  No

e) ulcerative colitis, Crohn's disease, cirrhosis of the liver, hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment?

- Yes  No

f) Paget's disease, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder?

- Yes  No

g) mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders or alcohol or drug abuse?

- Yes  No

h) incontinence, any ostomy present due to disease, an organ transplant other than corneal?

- Yes  No

19. Within the past **2 years**, have you consulted a physician, been diagnosed or received treatment for any condition not listed above, including dizziness, vertigo, tremors, seizures, depression, anxiety, amputation, arthritis, asthma, osteoporosis, urinary incontinence, heart rhythm disorders, heart bypass or heart attack?

- Yes  No

If Yes, give information regarding diagnosis or condition.

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## SECTION E

### NOTICE TO MEDICARE SUPPLEMENT APPLICANT

**The Applicant must read the following statements or the Agent must read the following statements to the Applicant.**

You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare Benefits.

You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. If, after purchasing this coverage, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement coverage 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 coverage (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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 the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

## SECTION F

**AGREEMENT** — I have read or had read to me my completed application (including the statements in Section E). My answers are true and complete. I understand my coverage, if issued, will begin on the date of issue shown in my policy. I realize any false statement or misrepresentation in my application may result in loss of coverage under my policy. If application taken over the phone, I agree that my electronic signature serves as my original signature.

**FRAUD WARNING** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application is guilty of a crime and may be subject to fines and confinement in prison.

**ACKNOWLEDGMENT** — I have received the Outline of Coverage and *Guide to Health Insurance for People with Medicare* from the Agent.

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### A TELEPHONE INTERVIEW WILL BE CONDUCTED.

**What will be the best time to contact the Applicant for the telephone interview?** \_\_\_\_\_

\_\_\_\_\_

# AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

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

I understand that:

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

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

\_\_\_\_\_

Date

\_\_\_\_\_

Applicant's Signature

\_\_\_\_\_

Witness

\_\_\_\_\_

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

## AGENT'S STATEMENT

I certify that: 1) I asked the Applicant the questions in the application and truthfully and accurately recorded the answers; 2) the answers did not conflict with my observations and knowledge of the Applicant; and 3) if applicable, I gave the outline of coverage and *Guide to Health Insurance for People with Medicare* to the Applicant and a copy of the appropriate form(s) and/or disclosure(s).

I also certify that: 1) the Applicant has read, or had read to him or her, the completed application (including the statements in Section E); and 2) the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

The company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant and which are currently in force are (if none, write "NONE"): \_\_\_\_\_

The company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant during the past 5 years and which are not currently in force are (if none, write "NONE"): \_\_\_\_\_

As the Agent, do you have any knowledge or reason to believe that replacement of existing insurance may be involved?...  Yes  No

### AGENT INFORMATION

Name (printed) \_\_\_\_\_ Signature \_\_\_\_\_

Agent Code \_\_\_\_\_ Date Signed \_\_\_\_\_

Email \_\_\_\_\_ Fax \_\_\_\_\_ Phone \_\_\_\_\_

Premium Quoted \$ \_\_\_\_\_

Special Requests: \_\_\_\_\_

Initial Premium \$ \_\_\_\_\_

No money collected. Initial premium is to be drafted.

Receipt Given: Yes  No

Mail Policy to: Insured  Agent

## AUTHORIZATION TO MY BANK

### Bank Information

Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree that should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. If application taken over the phone, I agree that my electronic signature serves as my original signature.

\_\_\_\_\_   
Date Signed

Signature (as it appears on bank records)

Complete if no personalized deposit ticket is available.

Account Number \_\_\_\_\_

Routing Number \_\_\_\_\_

## PREAUTHORIZED CHECK AUTHORIZATION

**Attach Voided Check  
or Deposit Ticket Here  
and Sign Authorization**

Checking

Savings

## RECEIPT

**IF PREMIUM IS COLLECTED, CHECK OR MONEY ORDER FOR INITIAL PREMIUM MUST ACCOMPANY APPLICATION. ALL CHECKS AND MONEY ORDERS MUST BE PAYABLE TO STANDARD LIFE AND ACCIDENT INSURANCE COMPANY.** If a policy is not issued, the initial premium will be refunded to the Applicant. If a policy is issued, coverage will begin on the date of issue shown in the policy.

Received from \_\_\_\_\_ on \_\_\_\_\_ Date

an application for Plan \_\_\_\_\_ and a Check  Money Order  for \$ \_\_\_\_\_

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

Agent's Signature \_\_\_\_\_

## DISCLOSURE NOTICE

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

Medical Information Bureau (MIB) Pre-notification – Information regarding your insurability will be treated as confidential. Standard Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Standard Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

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

**STANDARD LIFE AND ACCIDENT INSURANCE COMPANY • P.O. Box 696870 • San Antonio, Texas 78269 • 888.350.1488**

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**Standard Life and Accident Insurance Company**  
P.O. Box 696870, San Antonio, TX 78269  
888.350.1488



Application ID:  
Policy ID:

Standard Life and Accident Insurance Company  
Medicare Supplement Application • P.O. Box 696870 • San Antonio, Texas 78269

<b>SECTION A</b>		
<b>APPLICANT INFORMATION</b>		
<b>Last Name</b>	<b>First Name</b>	<b>MI</b>
DUCK	DONALD	A
<b>Date Of Birth</b>	<b>Age</b>	
03/20/1942		
<b>Home Address</b>		
123 S MAIN ST		
<b>City</b>	<b>State</b>	<b>Zip Code</b>
DISNEYLAND	CA	55555
<b>Home Phone</b>	<b>Best Time to Call (AM/PM)</b>	<b>Email Address</b>
(876)354-0012	AM	DDUCK@DISNEY.COM
<b>Billing Address (if different)</b>		
N/A		
<b>City</b>	<b>State</b>	<b>Zip Code</b>
N/A	N/A	N/A

<b>SECTION B</b>	
<b>Application Type</b>	
NEW POLICY	
<b>Medicare Supplement Plan</b>	<b>Gender</b>
PLAN B	M
<b>Payment Mode</b>	
QUARTERLY	
<b>Requested Effective Date</b>	
01/01/2010	
<b>Medicare claim number</b>	
123-23-1234A	

**SECTION C**

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

**To the best of your knowledge:**

7. Did you turn 65 in the last 6 months? YES

8. Did you enroll in Medicare Part B in the last 6 months? YES

If Yes, what is the effective date? 01/01/2010

9. Are you covered for medical assistance through the state Medicaid program? YES

(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, will Medicaid pay your premiums for this Medicare Supplement policy? YES

If Yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? YES

10. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START: 12/01/2001 END: 01/01/2010

If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? YES

Was this your first time in this type of Medicare plan? YES

Did you drop a Medicare Supplement policy to enroll in the Medicare plan? YES

11. Do you have another Medicare Supplement policy in force? YES

If so, with what company, and what plan do you have?

GENERAL MEDICAL INSURANCE

If so, do you intend to replace your current Medicare Supplement policy with this policy? YES

12. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) YES

If so, with what company and what kind of policy?

GENERAL MEDICAL INSURANCE WHOLE HEALTH

What are your dates of coverage under the other policy?

If you are still covered under the other policy, leave "END" blank.

START: 12/01/2009 END: 01/01/2010

13. Do you qualify for open enrollment? YES

If Yes, please explain.

I HAVE REACHED MY 65TH BIRTHDAY

14. Do you qualify for guarantee issue? YES

If Yes, please submit proof with application.

**SECTION D**

**COMPLETE IF APPLYING FOR MEDICARE SUPPLEMENT ON A NON-OPEN ENROLLMENT OR NON-GUARANTEE ISSUE BASIS.**

Tobacco Use: TOBACCO USER

Height: 5'10" Weight: 195

**UNDER OPEN ENROLLMENT, HEALTH QUESTIONS AR NOT REQUIRED TO BE ANSWERED.**

**If the answer to any question in Section D (15-18h) is Yes, the application should not be submitted.**

15. Are you now bedridden, confined to a nursing home, assisted living facility or hospital, or receiving the services of a home health care agency? YES
- 
16. Within the past **10 years**, have you been treated for or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection? YES
- 
17. Within the past **2 years**, have you:
- 17a. had or been recommended to have medical tests or treatment or surgery which have not been done or for which results have not been given? YES
- 
- 17b. been hospitalized 2 or more times or confined to a nursing home or required assistance or supervision by another person for dressing, eating, personal hygiene (bathing or toileting), walking or transferring to or from a bed or chair or suffered a fracture of the spine or hip? YES
- 
- 17c. required the use of a wheelchair, walker or cane? YES
- 
- 17d. been advised to have cataract surgery or other eye surgery that has not been performed? YES
- 
18. Do you now have or within the past **2 years** have you had or been advised to have treatment, surgery or to take prescription medication for:
- 18a. cancer (excluding basal or squamous cell), Hodgkin's disease, leukemia, or melanoma; even if the conditions are in remission? YES
- 
- 18b. congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder, heart disease, enlarged heart, transient ischemic attack, stroke, heart or heart valve surgery, angioplasty, pacemaker, or stent placement? YES
- 
- 18c. uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene? YES
- 
- 18d. emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen? YES
- 
- 18e. ulcerative colitis, Crohn's disease, cirrhosis of the liver, hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment? YES
-

**SECTION D (continued)**

18f. Paget's disease, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder? YES

18g. mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders or alcohol or drug abuse? YES

18h. incontinence, any ostomy present due to disease, an organ transplant other than corneal? YES

19. Within the past **2 years**, have you consulted a physician, been diagnosed or received treatment for any condition not listed above, including dizziness, vertigo, tremors, seizures, depression, anxiety, amputation, arthritis, asthma, osteoporosis, urinary incontinence, heart rhythm disorders, heart bypass or heart attack? YES

If Yes, give information regarding diagnosis or condition.

**Date of treatment From:** 12/06  
**Date of treatment To:** 10/07  
**Reason for Check-up, Diagnosis, Illness or Frequency of Attacks:** SORENESS IN FOOT  
**Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery:** GOUT, MEDICATION, COMPLETE RECOVERY  
**Name and Address of Each Physician, Practitioner, and Medical Facility:** DR. NIGLE HONEYCUT, 123 IMAGINATION BLVD, EPCOT, FL 22222

**SECTION E**

**NOTICE TO MEDICARE SUPPLEMENT APPLICANT**

**The Applicant must read the following statements or the Agent must read the following statements to the Applicant.**

You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare Benefits.

You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. If after purchasing this coverage, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement coverage 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 coverage (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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 the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

**SECTION F**

**AGREEMENT** - I have read or had read to me my completed application (including the statements in Section E). My answers are true and complete. I understand my coverage, if issued, will begin on the date of issue shown in my policy. I realize any false statement or misrepresentation in my application may result in loss of coverage under my policy. If application taken over the phone, I agree that my electronic signature serves as my original signature.

**FRAUD WARNING** - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**ACKNOWLEDGMENT** - I have received the Outline of Coverage and *Guide to Health Insurance for People with Medicare* from the Agent.

I agree that my electronic signature on this Enrollment Application serves as my original signature.

**Applicant's Signature**

<b>First Name :</b>	DONALD	<b>Last Name:</b>	DUCK	<b>Date:</b>	01/20/2010
<b>City :</b>	DISNEYLAND	<b>State:</b>	CA	<b>Zip:</b>	55555



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

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

I understand that:

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

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

**I agree that my electronic signature serves as my original signature.**

**Applicant's Signature**

<b>First Name :</b>	DONALD	<b>Last Name:</b>	DUCK	<b>Date:</b>	01/20/2010
---------------------	--------	-------------------	------	--------------	------------

<b>Witness :</b>	SNUFFY SMITH
------------------	--------------

<b>Personal Representative :</b>	N/A
----------------------------------	-----

**AGENT'S STATEMENT**

I certify that: 1) I asked the Applicant the questions in the application and truthfully and accurately recorded the answers; 2) the answers did not conflict with my observations and knowledge of the Applicant; and 3) if applicable, I gave the outline of coverage and *Guide to Health Insurance for People with Medicare* to the Applicant and a copy of the appropriate form(s) and/or disclosure(s).

I also certify that: 1) the Applicant has read, or had read to him or her, the completed application (including the statements in Section E); and 2) the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

The company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant and which are currently in force are (if none, write "NONE"):

The company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant during the past 5 years and which are not currently in force are (if none, write "NONE"):

As the agent, do you have any knowledge or reason to believe that replacement of existing insurance may be involved?

**Agent Information**

**First Name:**  **Last Name:**

**Agent Code:**  **Date Signed:**

**Phone:**  **Fax# :**  **Email:**

**Premium Quoted:**  **Initial Premium :**

**No money collected. Initial premium is to be drafted.** YES

**Receipt Given:** YES

**Mail Policy to:** INSURED

**Special Requests:**

THERE ARE NO SPECIAL INSTRUCTIONS

## DISCLOSURE NOTICE

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

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Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901(TTY 866.346.3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Standard Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

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

**STANDARD LIFE AND ACCIDENT INSURANCE COMPANY • P.O. Box 696870 • San Antonio, Texas 78269 • 888.350.1488**

Protect Your  
Health &  
Your Future



**MEDICARE SUPPLEMENT  
INSURANCE**

An Informative Brochure from  
Standard Life and Accident  
Insurance Company

**Standard Life**  
and Accident  
Insurance Company  
A Member of the American National Family of Companies

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San Antonio, Texas 78269

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ST-2341

MSB10

# Protect Your Health & Your Future



## MEDICARE SUPPLEMENT INSURANCE

*from*

Standard Life and Accident Insurance Company  
(Standard Life)

*Presented by* \_\_\_\_\_  
State Licensed Agent

**IMPORTANT:** Standard Life and Accident Insurance Company and its agents are not connected in any way with the federal or state government or Medicare. This brochure is a description of the essential benefit features and provisions of the insurance plan. For full details, please refer to the appropriate policy form for your state.

## Choose the Company *and* the Insurance Plan *that is right for You.*

Medicare is providing a vital service to millions of America's senior citizens, assuring them a broad range of health care services are available when they are needed. But, while Medicare eases the burden of health care costs, it by no means eliminates it, and what Medicare **does not pay is your** personal financial responsibility. Standard Life, a leader in the senior market, has developed supplemental products which help to cover expenses not covered in traditional Medicare coverage.

Your Standard Life representative can help you analyze your needs and choose the Medicare Supplement insurance plan that meets your needs and your budget.

**Medicare Supplement insurance plans are standardized by federal and state law.**

**Only standardized insurance plans may be offered to supplement Medicare.**

## Standard Life Experience *and* Focus at Work for You.

Helping senior citizens manage their health care costs has been a primary interest of Standard Life since the inception of Medicare. The insurance plans we now offer reflect years of experience and focus on meeting those needs.

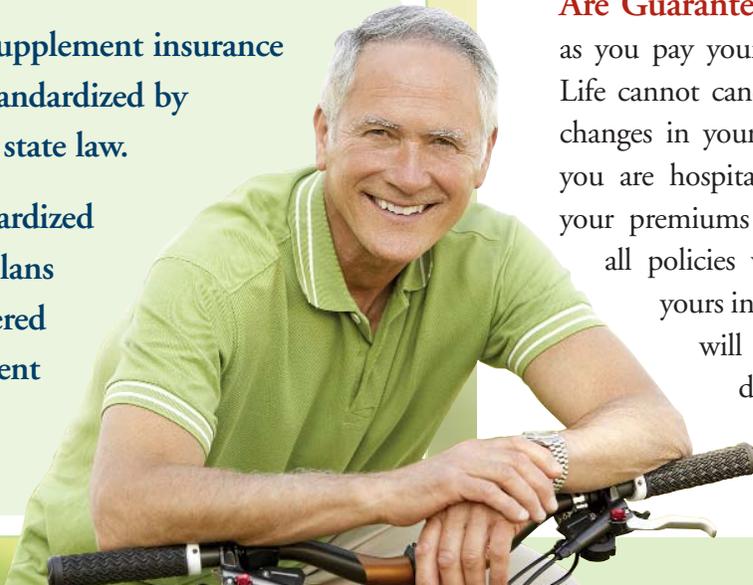
### Medicare Supplement Plans:

**Pay regardless** of any other insurance you may have.

**Cover prior health conditions immediately**, with no exclusion for pre-existing conditions.

**Cover foreign travel medical care** (Plans C, D, F, F(HD)<sup>1</sup>, G and N) for emergencies while traveling outside the United States.

**Are Guaranteed Renewable**, for life, as long as you pay your premiums when due. Standard Life cannot cancel your policy, regardless of any changes in your health or the number of times you are hospitalized. Standard Life can change your premiums if it changes the premiums on all policies with the same form number as yours in the state where you live, but there will never be more than one change during any 12 month period.



# Choose the Medicare Supplement Plan *that meets Your needs.*

If a mark appears in a column, then that Medicare Supplement plan covers 100% of the benefit described. If there is no mark, the plan does not cover that benefit. The deductible must be satisfied before coinsurance is payable, unless the plan also pays the deductible.

Medicare Supplement Benefits	Plans Available							
	A	B	C	D	F	F(HD) <sup>1</sup>	G	N
Medicare Part A Coinsurance and Coverage for Hospital Benefits	■	■	■	■	■	■	■	■
Medicare Part B Coinsurance	■	■	■	■	■	■	■	■ <sup>2</sup>
Blood (First 3 Pints)	■	■	■	■	■	■	■	■
Skilled Nursing Facility Care Coinsurance			■	■	■	■	■	■
Medicare Part A Deductible		■	■	■	■	■	■	■
Medicare Part B Deductible			■		■	■		
Medicare Part B Excess Charges					■	■	■	
Foreign Travel Emergency (up to Plan Limits <sup>3</sup> )			■	■	■	■	■	■
Preventive Care Coinsurance (included in Part B Coinsurance)	■	■	■	■	■	■	■	■ <sup>2</sup>

<sup>1</sup> This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year deductible. Benefits from this plan will not begin until out-of-pocket expenses (expenses that would ordinarily be paid by the policy) exceed the calendar year deductible.

<sup>2</sup> Except for a copayment for office visits and a copayment for emergency room visits.

<sup>3</sup> You must also pay a separate deductible for foreign travel emergency.

Policy Form Series 2010-1006 availability varies by state. Medicare Supplement standardized plans are offered to Medicare qualified individuals due to disability in some states. The policy has exclusions and limitations.

Copayments and deductibles are subject to annual adjustment.

# Brief Description of Policy Benefits

*(All insurance plans are not available in all states)*

## Basic Care Benefits:

Pays the Part A coinsurance amount for the 61st through the 90th day of hospitalization, and for each of Medicare's 60 lifetime reserve days. After lifetime reserve days are exhausted, pays for 100% of Medicare Part A eligible hospital expenses up to a maximum of 365 days. Pays for the cost of the first 3 pints of blood under Medicare Parts A and B. After the Part B annual deductible is met, pays for the coinsurance amount (generally 20% of the Medicare approved amount). *Plans A, B, C, D, F, F(HD)<sup>1</sup>, G, N*

## Skilled Nursing Care:

Pays the coinsurance amount for Medicare approved skilled nursing care for days 21 through 100 in a Medicare approved facility, following a 3-day hospitalization. *Plans C, D, F, F(HD)<sup>1</sup>, G, N*

## Part A Deductible:

Pays the Medicare Part A inpatient hospital deductible per benefit period. *Plans B, C, D, F, F(HD)<sup>1</sup>, G, N*

## Part B Deductible:

Pays the annual Part B deductible. *Plans C, F, F(HD)<sup>1</sup>*

## Foreign Travel:

Pays 80% of costs (not covered by Medicare) for emergency care due to a sudden and unexpected injury or sickness during the first 60 consecutive

## Foreign Travel *(continued)*:

days of travel in a foreign country; subject to \$250 annual deductible and \$50,000 lifetime maximum.

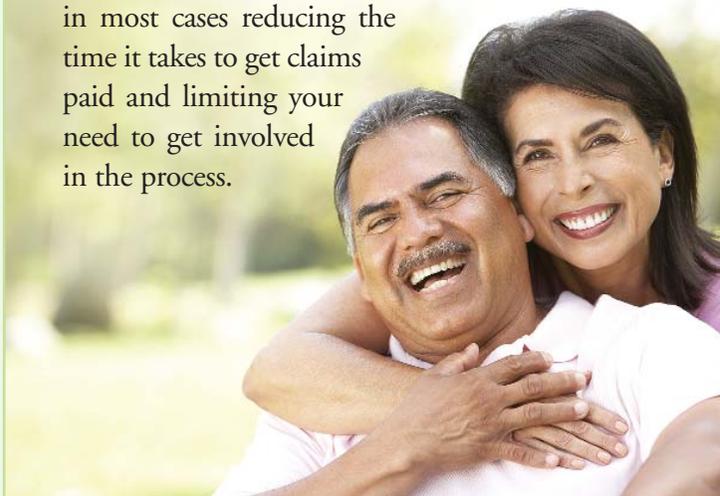
*Plans C, D, F, F(HD)<sup>1</sup>, G, N*

## Why Standard Life is the Company for You.

Standard Life is one of the nation's largest and most experienced providers of insurance for senior citizens. The Company is highly rated and has a well-established history of developing products to help solve the problem of the high cost of medical and hospital expenses not covered by traditional Medicare.

## "Quick Response" Claim System

Based on years of experience helping older Americans manage health expenses, Standard Life has developed procedures to streamline and simplify claim payment. Our computerized system allows us to work directly with Medicare providers throughout the United States, in most cases reducing the time it takes to get claims paid and limiting your need to get involved in the process.





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A Stock Company, hereafter referred to as "We", "Us", "Our" or "the Company"  
Home Office: One Moody Plaza, Galveston, Texas 77550  
[1-888-350-1488]

**POLICY ENDORSEMENT**

**PLAN OPTION A**

This Endorsement is a part of the Policy and is added to the Covered Person's Policy on their Policy Date of Issue.

**BASIC BENEFITS**

**PART A BENEFIT.** We will pay a benefit equal to the Part A Medicare Eligible Expenses You incur for hospitalization to the extent such expenses are not covered by Medicare for: 1) the 61st day through the 90th day in any Benefit Period and; 2) each Lifetime Reserve Day used.

Upon exhaustion of Your Medicare hospital inpatient coverage including all Your Lifetime Reserve Days, We will pay coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses You incur for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, to the same extent such expenses would have been covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuing payment as payment in full and may not bill You for any balances.

**PART A AND B BENEFIT.** We will pay a benefit for the reasonable cost of the first 3 pints of blood You receive during each Calendar Year under Part A or Part B (not both) unless replaced in accordance with federal regulations. Equivalent quantities of packed red blood cells as defined under federal regulations will be considered the same as 3 pints of blood.

**PART B BENEFIT.** We will pay a benefit equal to the Coinsurance Amount (or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount) of Your Part B Medicare Eligible Expenses regardless of hospital confinement, subject to the Medicare Part B Deductible.

**PART A BENEFIT** We will pay a benefit for the cost sharing You incur for all Part A Medicare eligible Hospice Care and Respite Care expenses.

**ADDITIONAL BENEFITS**

You have chosen Plan Option A. There are no additional benefits for this policy. Only the basic benefits apply.

This Endorsement is signed below on behalf of Standard Life and Accident Insurance Company by its duly authorized officers.



Secretary

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**POLICY ENDORSEMENT**

**PLAN OPTION B**

This Endorsement is a part of the Policy and is added to the Covered Person's Policy on their Policy Date of Issue.

**BASIC BENEFITS**

**PART A BENEFIT.** We will pay a benefit equal to the Part A Medicare Eligible Expenses You incur for hospitalization to the extent such expenses are not covered by Medicare for: 1) the 61st day through the 90th day in any Benefit Period and; 2) each Lifetime Reserve Day used.

Upon exhaustion of Your Medicare hospital inpatient coverage including all Your Lifetime Reserve Days, We will pay coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses You incur for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, to the same extent such expenses would have been covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuing payment as payment in full and may not bill You for any balance.

**PART A AND B BENEFIT.** We will pay a benefit for the reasonable cost of the first 3 pints of blood You receive during each Calendar Year under Part A or Part B (not both) unless replaced in accordance with federal regulations. Equivalent quantities of packed red blood cells as defined under federal regulations will be considered the same as 3 pints of blood.

**PART B BENEFIT.** We will pay a benefit equal to the Coinsurance Amount (or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount) of Your Part B Medicare Eligible Expenses regardless of hospital confinement, subject to the Medicare Part B Deductible.

**PART A BENEFIT** We will pay a benefit for the cost sharing You incur for all Part A Medicare eligible hospice care and respite care expenses.

**ADDITIONAL BENEFITS**

**PART A DEDUCTIBLE BENEFIT** We will pay a benefit for all of the Medicare Part A inpatient hospital deductible amount per Benefit Period.

This Endorsement is signed below on behalf of Standard Life and Accident Insurance Company by its duly authorized officers.



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**POLICY ENDORSEMENT**

**PLAN OPTION C**

This Endorsement is a part of the Policy and is added to the Covered Person's Policy on their Policy Date of Issue.

**BASIC BENEFITS**

**PART A BENEFIT** We will pay a benefit equal to the Part A Medicare Eligible Expenses You incur for hospitalization to the extent such expenses are not covered by Medicare for: 1) the 61st day through the 90th day in any Benefit Period and; 2) each Lifetime Reserve Day used.

Upon exhaustion of Your Medicare hospital inpatient coverage including all Your Lifetime Reserve Days, We will pay coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses You incur for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, to the same extent such expenses would have been covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuing payment as payment in full and may not bill You for any balance.

**PART A AND B BENEFIT** We will pay a benefit for the reasonable cost of the first 3 pints of blood You receive during each Calendar Year under Part A or Part B (not both) unless replaced in accordance with federal regulations. Equivalent quantities of packed red blood cells as defined under federal regulations will be considered the same as 3 pints of blood.

**PART B BENEFIT** We will pay a benefit equal to the Coinsurance Amount (or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount) of Your Part B Medicare Eligible Expenses regardless of hospital confinement, subject to the Medicare Part B Deductible.

**PART A BENEFIT** We will pay a benefit for the cost sharing You incur for all Part A Medicare eligible hospice care and respite care expenses.

**ADDITIONAL BENEFITS**

**PART A DEDUCTIBLE BENEFIT** We will pay a benefit for all of the Medicare Part A inpatient hospital deductible amount per Benefit Period.

**SKILLED NURSING CO-INSURANCE BENEFIT** We will pay a benefit for post hospital Skilled Nursing Facility care eligible under Part A of Medicare. The benefit will be for the 21st through the 100th day of confinement during each Benefit Period. The benefit will be equal to Your actual billed charges, but not more than Your Coinsurance Amount.

**PART B DEDUCTIBLE BENEFIT** We will pay a benefit for all of the Medicare Part B Deductible amount You incur per Calendar Year regardless of Hospital confinement.

**EMERGENCY CARE IN A FOREIGN COUNTRY BENEFIT** We will pay a benefit if: 1) You require hospital, Doctor or medical care due to the sudden and unexpected onset of an injury or sickness while You are in a foreign country; 2) the care is not covered by Medicare; and 3) the care would have been covered by Medicare if provided in the United States. The care must begin during the first 60 consecutive days of Your trip outside the United States. The benefit will be equal to 80% of the billed charges for Medicare eligible expenses after a calendar year deductible of \$250.00. The maximum benefit payable during Your lifetime is \$50,000.

This Endorsement is signed below on behalf of Standard Life and Accident Insurance Company by its duly authorized officers.



Secretary

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**POLICY ENDORSEMENT**

**PLAN OPTION D**

This Endorsement is a part of the Policy and is added to the Covered Person's Policy on their Policy Date of Issue.

**BASIC BENEFITS**

**PART A BENEFIT** We will pay a benefit equal to the Part A Medicare Eligible Expenses You incur for hospitalization to the extent such expenses are not covered by Medicare for: 1) the 61st day through the 90th day in any Benefit Period and; 2) each Lifetime Reserve Day used.

Upon exhaustion of Your Medicare hospital inpatient coverage including all Your Lifetime Reserve Days, We will pay coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses You incur for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, to the same extent such expenses would have been covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuing payment as payment in full and may not bill You for any balance.

**PART A AND B BENEFIT** We will pay a benefit for the reasonable cost of the first 3 pints of blood You receive during each Calendar Year under Part A or Part B (not both) unless replaced in accordance with federal regulations. Equivalent quantities of packed red blood cells as defined under federal regulations will be considered the same as 3 pints of blood.

**PART B BENEFIT** We will pay a benefit equal to the Coinsurance Amount (or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount) of Your Part B Medicare Eligible Expenses regardless of hospital confinement, subject to the Medicare Part B Deductible.

**PART A BENEFIT** We will pay a benefit for the cost sharing You incur for all Part A Medicare eligible hospice care and respite care expenses.

**ADDITIONAL BENEFITS**

**PART A DEDUCTIBLE BENEFIT** We will pay a benefit for all of the Medicare Part A inpatient hospital deductible amount per Benefit Period.

**SKILLED NURSING CO-INSURANCE BENEFIT** We will pay a benefit for post hospital Skilled Nursing Facility care eligible under Part A of Medicare. The benefit will be for the 21st through the 100th day of confinement during each Benefit Period. The benefit will be equal to Your actual billed charges, but not more than Your Coinsurance Amount.

**EMERGENCY CARE IN A FOREIGN COUNTRY BENEFIT** We will pay a benefit if: 1) You require hospital, Doctor or medical care due to the sudden and unexpected onset of an injury or sickness while You are in a foreign country; 2) the care is not covered by Medicare; and 3) the care would have been covered by Medicare if provided in the United States. The care must begin during the first 60 consecutive days of Your trip outside the United States. The benefit will be equal to 80% of the billed charges for Medicare eligible expenses after a calendar year deductible of \$250.00. The maximum benefit payable during Your lifetime is \$50,000.

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**POLICY ENDORSEMENT**

**PLAN OPTION F**

This Endorsement is a part of the Policy and is added to the Covered Person's Policy on their Policy Date of Issue.

**BASIC BENEFITS**

**PART A BENEFIT** We will pay a benefit equal to the Part A Medicare Eligible Expenses if You incur expenses for hospitalization to the extent such expenses are not covered by Medicare for: 1) the 61st day through the 90th day in any Benefit Period and; 2) each Lifetime Reserve Day used.

Upon exhaustion of Your Medicare hospital inpatient coverage including all Your Lifetime Reserve Days, We will pay coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses You incur for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, to the same extent such expenses would have been covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuing payment as payment in full and may not bill You for any balance.

**PART A AND B BENEFIT** We will pay a benefit for the reasonable cost of the first 3 pints of blood You receive during each Calendar Year under Part A or Part B (not both) unless replaced in accordance with federal regulations. Equivalent quantities of packed red blood cells as defined under federal regulations will be considered the same as 3 pints of blood.

**PART B BENEFIT** We will pay a benefit equal to the Coinsurance Amount (or in the case of Hospital outpatient department services paid under a prospective payment system, the co-payment amount) of Your Part B Medicare Eligible Expenses regardless of Hospital confinement, subject to the Medicare Part B Deductible.

**PART A BENEFIT** We will pay a benefit for the cost sharing You incur for all Part A Medicare eligible hospice care and respite care expenses.

**ADDITIONAL BENEFITS**

**PART A DEDUCTIBLE BENEFIT** We will pay a benefit for all of the Medicare Part A inpatient hospital deductible amount per Benefit Period.

**SKILLED NURSING CO-INSURANCE BENEFIT** We will pay a benefit for post hospital Skilled Nursing Facility care eligible under Part A of Medicare. The benefit will be for the 21st through the 100th day of confinement during each Benefit Period. The benefit will be equal to Your actual billed charges, but not more than Your Coinsurance Amount.

**PART B DEDUCTIBLE BENEFIT** We will pay a benefit for all of the Medicare Part B Deductible amount You incur per Calendar Year regardless of Hospital confinement.

**PART B EXCESS CHARGES BENEFIT.** We will pay a benefit equal to 100% of the difference, if any, between Your actual Medicare Part B charges as billed and Your Medicare approved Part B charges, subject to any charge limitations established by the Medicare program or state law.

**EMERGENCY CARE IN A FOREIGN COUNTRY BENEFIT** We will pay a benefit if: 1) You require Hospital, physician, or medical care due to the sudden and unexpected onset of an Injury or Sickness while they are in a foreign country; 2) the care is not covered by Medicare; and 3) the care would have been covered by Medicare if provided in the United States. The care must begin during the first 60 consecutive days of Your trip outside the United States. The benefit will be equal to 80% of the billed charges for Medicare eligible expenses after a Calendar Year deductible of \$250.00. The maximum benefit payable during Your lifetime is \$50,000.

This Endorsement is signed below on behalf of Standard Life and Accident Insurance Company by its duly authorized officers.

A handwritten signature in black ink, appearing to read "J. Mark Flippin". The signature is written in a cursive style with a large initial "J" and a long, sweeping underline.

Secretary

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**POLICY ENDORSEMENT**

**PLAN OPTION F(HD) – HIGH DEDUCTIBLE OPTION**

This Endorsement is a part of the Policy and is added to the Covered Person's Policy on their Policy Date of Issue.

**ANNUAL POLICY DEDUCTIBLE**

Your policy has an annual deductible that You must pay before any benefits are payable under the Policy. This deductible consists of Your out-of-pocket expenses, other than premiums, for services covered under the Policy. The annual deductible is in addition to any other deductibles stated in the Policy. The deductible is for the calendar year in which Your Policy is issued as shown on the Policy Schedule Page. The amount of the deductible is adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect changes in the Consumer Price Index.

**BASIC BENEFITS**  
**(After Annual Policy Deductible is met)**

**PART A BENEFIT** We will pay a benefit equal to the Part A Medicare Eligible Expenses if You incur expenses for hospitalization to the extent such expenses are not covered by Medicare for: 1) the 61st day through the 90th day in any Benefit Period and; 2) each Lifetime Reserve Day used.

Upon exhaustion of Your Medicare hospital inpatient coverage including all Your Lifetime Reserve Days, We will pay coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses You incur for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, to the same extent such expenses would have been covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuing payment as payment in full and may not bill You for any balance.

**PART A AND B BENEFIT** We will pay a benefit for the reasonable cost of the first 3 pints of blood You receive during each Calendar Year under Part A or Part B (not both) unless replaced in accordance with federal regulations. Equivalent quantities of packed red blood cells as defined under federal regulations will be considered the same as 3 pints of blood.

**PART B BENEFIT** We will pay a benefit equal to the Coinsurance Amount (or in the case of Hospital outpatient department services paid under a prospective payment system, the co-payment amount) of Your Part B Medicare Eligible Expenses regardless of Hospital confinement, subject to the Medicare Part B Deductible.

**PART A BENEFIT** We will pay a benefit for the cost sharing You incur for all Part A Medicare eligible hospice care and respite care expenses.

**ADDITIONAL BENEFITS**

**PART A DEDUCTIBLE BENEFIT** We will pay a benefit for all of the Medicare Part A inpatient hospital deductible amount per Benefit Period.

**SKILLED NURSING CO-INSURANCE BENEFIT** We will pay a benefit for post hospital Skilled Nursing Facility care eligible under Part A of Medicare. The benefit will be for the 21st through the 100th day of confinement during each Benefit Period. The benefit will be equal to Your actual billed charges, but not more than Your Coinsurance Amount.

**PART B DEDUCTIBLE BENEFIT** We will pay a benefit for all of the Medicare Part B Deductible amount You incur per Calendar Year regardless of Hospital confinement.

**PART B EXCESS CHARGES BENEFIT.** We will pay a benefit equal to 100% of the difference, if any, between Your actual Medicare Part B charges as billed and Your Medicare approved Part B charges, subject to any charge limitations established by the Medicare program or state law.

**EMERGENCY CARE IN A FOREIGN COUNTRY BENEFIT** We will pay a benefit if: 1) You require Hospital, physician, or medical care due to the sudden and unexpected onset of an Injury or Sickness while they are in a foreign country; 2) the care is not covered by Medicare; and 3) the care would have been covered by Medicare if provided in the United States. The care must begin during the first 60 consecutive days of Your trip outside the United States. The benefit will be equal to 80% of the billed charges for Medicare eligible expenses after a Calendar Year deductible of \$250.00. The maximum benefit payable during Your lifetime is \$50,000.

This Endorsement is signed below on behalf of Standard Life and Accident Insurance Company by its duly authorized officers.

A handwritten signature in black ink, appearing to read "J. Mark Flippin". The signature is written in a cursive style with a large initial "J" and "M".

Secretary

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**POLICY ENDORSEMENT**

**PLAN OPTION G**

This Endorsement is a part the Policy and is added to the Covered Person's Policy on their Policy Date of Issue.

**BASIC BENEFITS**

**PART A BENEFIT** We will pay a benefit equal to the Part A Medicare Eligible Expenses You incur for hospitalization to the extent such expenses are not covered by Medicare for: 1) the 61st day through the 90th day in any Benefit Period and; 2) each Lifetime Reserve Day used.

Upon exhaustion of Your Medicare hospital inpatient coverage including all Your Lifetime Reserve Days, We will pay coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses You incur for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, to the same extent such expenses would have been covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuing payment as payment in full and may not bill You for any balance.

**PART A AND B BENEFIT** We will pay a benefit for the reasonable cost of the first 3 pints of blood You receive during each Calendar Year under Part A or Part B (not both) unless replaced in accordance with federal regulations. Equivalent quantities of packed red blood cells as defined under federal regulations will be considered the same as 3 pints of blood.

**PART B BENEFIT** We will pay a benefit equal to the Coinsurance Amount (or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount) of Your Part B Medicare Eligible Expenses regardless of hospital confinement, subject to the Medicare Part B Deductible.

**PART A BENEFIT** We will pay a benefit for the cost sharing You incur for all Part A Medicare eligible hospice care and respite care expenses.

**ADDITIONAL BENEFITS**

**PART A DEDUCTIBLE BENEFIT** We will pay a benefit for all of the Medicare Part A inpatient hospital deductible amount per Benefit Period.

**SKILLED NURSING CO-INSURANCE BENEFIT** We will pay a benefit for post hospital Skilled Nursing Facility care eligible under Part A of Medicare. The benefit will be for the 21st through the 100th day of confinement during each Benefit Period. The benefit will be equal to Your actual billed charges, but not more than Your Coinsurance Amount.

**PART B EXCESS CHARGES BENEFIT.** We will pay a benefit equal to 100% of the difference, if any, between Your actual Medicare Part B charges as billed and Your Medicare approved Part B charges, subject to any charge limitations established by the Medicare program or state law.

**EMERGENCY CARE IN A FOREIGN COUNTRY BENEFIT.** We will pay a benefit if: 1) You require hospital, physician, or medical care due to the sudden and unexpected onset of an injury or sickness while You are in a foreign country; 2) the care is not covered by Medicare; and 3) the care would have been covered by Medicare if provided in the United States. The care must begin during the first 60 consecutive days of Your trip outside the United States. The benefit will be equal to 80% of the billed charges for Medicare eligible expenses after a calendar year deductible of \$250.00. The maximum benefit payable during Your lifetime is \$50,000.

This Endorsement is signed below in behalf of Standard Life and Accident Insurance Company by its duly authorized officers.

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Home Office: One Moody Plaza, Galveston, Texas 77550  
[1-888-350-1488]

**POLICY ENDORSEMENT**

**PLAN OPTION N**

This Endorsement is a part of the Policy and is added to the Covered Person's Policy on their Policy Date of Issue.

**BASIC BENEFITS**

**PART A BENEFIT.** We will pay a benefit equal to the Part A Medicare Eligible Expenses You incur for hospitalization to the extent such expenses are not covered by Medicare for: 1) the 61st day through the 90th day in any Benefit Period and; 2) each Lifetime Reserve Day used.

Upon exhaustion of Your Medicare hospital inpatient coverage including all Your Lifetime Reserve Days, We will pay coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses You incur for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, to the same extent such expenses would have been covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuing payment as payment in full and may not bill You for any balances.

**PART A AND B BENEFIT.** We will pay a benefit for the reasonable cost of the first 3 pints of blood You receive during each Calendar Year under Part A or Part B (not both) unless replaced in accordance with federal regulations. Equivalent quantities of packed red blood cells as defined under federal regulations will be considered the same as 3 pints of blood.

**PART B BENEFIT.** We will pay a benefit equal to the Coinsurance Amount (or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount) of Your Part B Medicare Eligible Expenses regardless of hospital confinement, subject to the Medicare Part B Deductible.

**PART A BENEFIT** We will pay a benefit for the cost sharing You incur for all Part A Medicare eligible Hospice Care and Respite Care expenses.

**ADDITIONAL BENEFITS**

**PART A DEDUCTIBLE BENEFIT** We will pay a benefit for all of the Medicare Part A inpatient hospital deductible amount per Benefit Period.

**SKILLED NURSING CO-INSURANCE BENEFIT** We will pay a benefit for post hospital Skilled Nursing Facility care eligible under Part A of Medicare. The benefit will be for the 21st through the 100th day of confinement during each Benefit Period. The benefit will be equal to Your actual billed charges, but not more than Your Coinsurance Amount.

**EMERGENCY CARE IN A FOREIGN COUNTRY BENEFIT** We will pay a benefit if: 1) You require hospital, Doctor or medical care due to the sudden and unexpected onset of an injury or sickness while You are in a foreign country; 2) the care is not covered by Medicare; and 3) the care would have been covered by Medicare if provided in the United States. The care must begin during the first 60 consecutive days of Your trip outside the United States. The benefit will be equal to 80% of the billed charges for Medicare eligible expenses after a calendar year deductible of \$250.00. The maximum benefit payable during Your lifetime is \$50,000.

**COPAYMENTS**

**OFFICE VISITS.** You will be responsible for a co-payment equal to the lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists).

**EMERGENCY ROOM.** You will be responsible for a co-payment equal to the lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit. This co-payment will be waived if You are admitted to any Hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

This Endorsement is signed below on behalf of Standard Life and Accident Insurance Company by its duly authorized officers.

A handwritten signature in black ink, appearing to read "J. Mark Flippin". The signature is written in a cursive style with a large initial "J" and a long, sweeping underline.

Secretary

SERFF Tracking Number: ANTX-126515349 State: Arkansas  
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 45265  
 Company Tracking Number:  
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010  
 Product Name: 2010 MEDICARE SUPPLEMENT  
 Project Name/Number: 2010 MEDICARE SUPPLEMENT/2010 MEDICARE SUPPLEMENT

**Rate Information**

Rate data applies to filing.

**Filing Method:** Serff  
**Rate Change Type:** Neutral  
**Overall Percentage of Last Rate Revision:** 0.000%  
**Effective Date of Last Rate Revision:** 03/25/2010  
**Filing Method of Last Filing:** New

**Company Rate Information**

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Standard Life and Accident Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: ANTX-126515349 State: Arkansas  
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 45265  
 Company Tracking Number:  
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010  
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## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved 04/19/2010	2010 Medicare Supplement Product	2010-1006-AR	New		AR Actuarial Memorandum w Rates.pdf

## Actuarial Certification

The anticipated loss ratio over the policy lifetime as well as in the third policy year is expected to be not less than 65%. This equals the minimum loss ratio requirement for group Medicare Supplement policies. This estimate is based on a projection of financial results.

Loss ratio, as used in this memorandum, means the present value of incurred claims divided by the present value of earned premiums.

To the best of my knowledge and belief:

- a) this filing is in compliance with the applicable laws and regulations of the state and is in compliance with the current standards of practice as promulgated by the Actuarial Standards Board.
- b) the benefits provided are reasonable in relation to the premiums charged; and
- c) the assumptions appropriately represent the expected values.



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3/23/2010

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Michael Shumate, ASA  
Health Actuary  
One Moody Plaza  
Galveston TX 77550-7999  
(281) 538-4827

Date

## Information Sheet

### I. Purpose

This actuarial memorandum is intended to support the initial filing of premium rates for Standard Life and Accident Insurance Company (SLAICO) Standardized Medicare Supplement Form 2010 and Plan Options A, B, C, D, F, F(hd), G and N. It is not intended for any other use or purpose.

### II. Renewability Provision

Form 2010 is Guaranteed Renewable. SLAICO reserves the right to change the premiums if such change applies to all policies in the same state of issue.

### III. Premium Rate Basis

Premiums rates vary by the requirements of the state of issue and will be either attained age, issue age or community rated, as each state requires. This memorandum is for Arkansas only. Plan Options are available to applicants aged 65 and over.

### IV. Underwriting

Open enrollment is available to persons who submit an application for this form during the six month period beginning with the first month in which the person attains the age of 65 or other state and/or federal specific requirements.

If the applicant is eligible for open enrollment, this form does not discriminate in pricing because of their health status, claims experience, receipt of health care or medical condition.

If the applicant is not eligible for open enrollment, home office underwriting is performed. There is no pre-existing limitation under this form in any case.

### V. Form Availability

This form will be available in your state upon receipt of approval and release by the home office. Release will be conditioned on any state requirements and the availability of marketing materials, if any.

This is a new form. It does not replace any existing form.

### VI. Benefits

Form 2010 offers Standardized Medicare Supplement Plan Options A, B, C, D, F, F(hd), G and N. Benefits are determined by the Plan Option chosen by the policyholder. Benefits and services covered are described in the 2010 NAIC Medicare Supplement Insurance Model Regulation. This form does not contain any innovative benefit as described in the regulation.

Standard Life and Accident Insurance Company  
Actuarial Memorandum for Medicare Supplement Policy Form 2010-1006  
(Referred to as Form 2010 in this memorandum)

**VII. Refund or Credit of Premium**

If, on the basis of experience reported, the benchmark loss ratio since inception exceeds the adjusted experience loss ratio since inception on a statewide basis for this form, then a refund or credit of premium will be given. The benchmark loss ratio is calculated via assumptions specified in the NAIC Medicare Supplement Insurance Model Regulation.

Any such refund would include interest from the end of the calendar year to the date of the refund or credit.

**VIII. Gross Annual Premiums and Area Factors**

Gross Annual Premiums, Area Factors and Rating Methodology by state are attached.

## Actuarial Assumptions

### 1. Method of Calculation

Premiums were calculated using a calendar year profit study. Such calculations were based on the present value of premiums, claims, expenses, commissions and investment income. The assumptions used are shown below. Incurred claims are calculated from paid claims plus the change in the claim reserve. Earned premium are calculated as the collected premium plus the change in unearned premium reserve.

### 2. Morbidity Basis

Average claim costs were based on studies of the company's own experience and actuarial judgement, supplemented with data supplied by Milliman & Robertson, Inc. from their Health Cost Guidelines for Ages 65 and Over.

Sample claim costs are shown in Exhibit I.

### 3. Effect of Initial Selection

Initial selection varies by issue class:

Duration	Selection Factors		
	Under-written	Open Enrollment	Guaranteed Issue
1	0.7255	0.8644	1.2136
2	0.8180	0.8225	1.2954
3	0.8200	0.8225	1.3359
4	0.8200	0.8225	1.3378
5+	0.8200	0.8225	1.3378
Issue Age	Distribution		
65	5.3%	93.8%	0.9%
66+	81.9%	6.3%	11.8%

### 4. Reserve Basis

Statutory Additional Reserves (policy reserves), where necessary, will be based on pricing claims costs, 2001 CSO mortality and interest rates determined by state law. An appropriate statutory margin will be applied to the claims costs. Policy reserves were not considered in calculating the loss ratios for this filing.

Standard Life and Accident Insurance Company  
 Actuarial Memorandum for Medicare Supplement Policy Form 2010-1006  
 (Referred to as Form 2010 in this memorandum)

5. Total Decrement Rates

Total Decrement Rates are shown in Exhibit II, attached to this memorandum. Mortality assumptions are 1991 US Population, extended with 105% of 2001 CSO Composite rates to age 120 (40% Males, 60% Females). Lapse rates are based on the experience of similar plans and judgment. Since there are no mortality-based benefits, mortality and lapse rates are not shown separately. Mortality is defined separately to facilitate calculation of shock lapse for future rate action filings.

6. Experience Base for Future Rate Adjustments

Future rate adjustments will be based on a review of actual experience of this policy form by state, to the extent credible. Nationwide experience and other relevant experience will also be considered to supplement such information. Trends and other variables affecting experience will be recognized in calculating future rate adjustments.

7. Commissions

Guaranteed Issue:                    5% All Years

All Other:

Issue Age	Policy Years	
	1 - 6	7+
65+	16.5%	5.0%

Commissions are a percentage of original premium, less the Part B Deductible premium (\$151 for 2010). Commissions may vary by state as the result of specific state requirements.

8. Other Percentage Expenses

Description of Percentage Expenses	Policy Years	
	1	2+
Premium Taxes and other percentage of premium expenses	29.4%	2.8%
Claims Expenses (Percentage of Incurred Claims)	5.5%	5.5%

9. Per Policy Expenses

Description of Per Policy Expenses	Amount
Issue and Underwriting Expense (At Issue)	\$153.53
Maintenance Expense (every policy year)	\$86.36

Standard Life and Accident Insurance Company  
 Actuarial Memorandum for Medicare Supplement Policy Form 2010-1006  
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10. Expected Modal Distribution and Modal Factors

Mode	Distribution	Factor
Annual	45.0%	1.0000
Semiannual	11.0%	0.5200
Quarterly	4.0%	0.2700
Special Monthly (Check-O-Matic)	40.0%	0.0875

11. Interest Rate for Determining Present Values

An interest rate of 5.5% per annum for all years.

12. Expected Distribution of Business by Age

Issue Age	Distribution by Issue Age
65	28.6%
66-69	18.7%
70-74	24.6%
75-79	15.2%
80-84	6.2%
85+	6.7%

13. Expected Distribution by Gender and Tobacco Use

Gender	Distribution
Female	60.0%
Male	40.0%

Tobacco Use	Distribution
Non-Tobacco User	90.0%
Tobacco User	10.0%

14. Expected Distribution of Business by Plan Option

Plan Option	Distribution by Plan Option
A	0.9%
B	0.6%
C	6.2%
D	20.2%
F	24.3%
F(hd)	9.1%
G	36.5%
N	2.2%

15. Average Annual Premium per Policy

The average annual premium is expected to be \$2,185 per policy at issue before application of area factors.

## Exhibit I

### Sample Average Annual Claim Costs

<b>Attained Age</b>	<b>Average Annual Claim Costs</b>
65	1,506
67	1,467
72	1,463
77	1,546
82	1,634
87	1,727
92	1,825
97	1,929
102	1,994

The sample claim costs are shown without selection adjustments, for states with a 1.0 area factor.

Standard Life and Accident Insurance Company  
 Actuarial Memorandum for Medicare Supplement Policy Form 2010-1006  
 (Referred to as Form 2010 in this memorandum)

## Exhibit II

### Total Decrement Rates

Duration	Issue Age						
	65	67	72	77	82	87	92
1	0.1307	0.1307	0.1307	0.1307	0.1307	0.1727	0.2290
2	0.1757	0.1757	0.1757	0.1757	0.1757	0.1757	0.2395
3	0.1990	0.1990	0.1990	0.1990	0.1990	0.1990	0.2710
4	0.1978	0.1978	0.1978	0.1978	0.1978	0.1978	0.2817
5	0.1763	0.1763	0.1763	0.1763	0.1878	0.2390	0.3266
6	0.1572	0.1572	0.1572	0.1572	0.1979	0.2566	0.3397
7	0.1401	0.1401	0.1401	0.1631	0.2082	0.2735	0.3468
8	0.1251	0.1298	0.1444	0.1698	0.2183	0.2925	0.3619
9	0.1274	0.1322	0.1493	0.1781	0.2283	0.3127	0.3836
10	0.1298	0.1349	0.1545	0.1878	0.2390	0.3303	0.4084
11	0.1322	0.1381	0.1600	0.1979	0.2566	0.3397	0.4370
12	0.1349	0.1419	0.1659	0.2082	0.2735	0.3468	0.4699
13	0.1381	0.1462	0.1725	0.2183	0.2925	0.3619	0.5082
14	0.1419	0.1510	0.1808	0.2283	0.3127	0.3836	0.5536
15	0.1462	0.1563	0.1905	0.2390	0.3303	0.4084	0.6079
16	0.1510	0.1618	0.2006	0.2566	0.3397	0.4370	0.6726
17	0.1563	0.1676	0.2109	0.2735	0.3468	0.4699	0.7487
18	0.1618	0.1743	0.2209	0.2925	0.3619	0.5082	0.8308
19	0.1676	0.1826	0.2308	0.3127	0.3836	0.5536	0.8952
20	0.1743	0.1922	0.2431	0.3303	0.4084	0.6079	0.9310
21	0.1826	0.2022	0.2566	0.3397	0.4370	0.6726	0.9518
22	0.1922	0.2125	0.2735	0.3468	0.4699	0.7487	0.9654
23	0.2022	0.2226	0.2925	0.3619	0.5082	0.8308	0.9737
24	0.2125	0.2324	0.3127	0.3836	0.5536	0.8952	0.9790
25	0.2226	0.2431	0.3303	0.4084	0.6079	0.9310	0.9834
26	0.2324	0.2566	0.3397	0.4370	0.6726	0.9518	0.9879
27	0.2431	0.2735	0.3468	0.4699	0.7487	0.9654	0.9923
28	0.2566	0.2925	0.3619	0.5082	0.8308	0.9737	0.9973
29	0.2735	0.3127	0.3836	0.5536	0.8952	0.9790	1.0000
30	0.2925	0.3303	0.4084	0.6079	0.9310	0.9834	
31	0.3127	0.3397	0.4370	0.6726	0.9518	0.9879	
32	0.3303	0.3468	0.4699	0.7487	0.9654	0.9923	
33	0.3397	0.3619	0.5082	0.8308	0.9737	0.9973	
34	0.3468	0.3836	0.5536	0.8952	0.9790	1.0000	
35	0.3619	0.4084	0.6079	0.9310	0.9834		
36	0.3836	0.4370	0.6726	0.9518	0.9879		
37	0.4084	0.4699	0.7487	0.9654	0.9923		
38	0.4370	0.5082	0.8308	0.9737	0.9973		
39	0.4699	0.5536	0.8952	0.9790	1.0000		

Standard Life and Accident Insurance Company  
 Actuarial Memorandum for Medicare Supplement Policy Form 2010-1006  
 (Referred to as Form 2010 in this memorandum)

**Exhibit II**  
 Total Decrement Rates (Con't)

Duration	Issue Age						
	65	67	72	77	82	87	92
40	0.5082	0.6079	0.9310	0.9834			
41	0.5536	0.6726	0.9518	0.9879			
42	0.6079	0.7487	0.9654	0.9923			
43	0.6726	0.8308	0.9737	0.9973			
44	0.7487	0.8952	0.9790	1.0000			
45	0.8308	0.9310	0.9834				
46	0.8952	0.9518	0.9879				
47	0.9310	0.9654	0.9923				
48	0.9518	0.9737	0.9973				
49	0.9654	0.9790	1.0000				
50	0.9737	0.9834					
51	0.9790	0.9879					
52	0.9834	0.9923					
53	0.9879	0.9973					
54	0.9923	1.0000					
55	0.9973						
56	1.0000						

### Exhibit III Expected Durational Loss Ratios

Year from Issue	Earned Premium	Incurred Claims	Loss Ratio
1	2,185	1,340	61%
2	2,087	1,338	64%
3	1,858	1,207	65%
4	1,578	1,048	66%
5	1,367	912	67%
6	1,213	816	67%
7	1,098	744	68%
8	1,008	689	68%
9	929	641	69%
10	854	593	70%
11	781	547	70%
12	710	501	71%
13	644	458	71%
14	580	416	72%
15	520	375	72%
16	463	337	73%
17	410	300	73%
18	360	265	74%
19	314	233	74%
20	272	203	75%
Lifetime*	14,642	9,774	67%

\* Calculated as the Present Value of Earned Premium and Incurred Claims at 5.5%.  
 Claims trend of 10% grading to 8% was used. Premium increases matched trend.

**EXHIBIT IV**  
**Standard Life and Accident Insurance Company**  
**Policy Form 2010-1006-AR**  
**Base Annual Premium Rates**

Community	Plan Option A		Plan Option B		Plan Option C		Plan Option D		Plan Option F		Plan Option F(hd)		Plan Option G		Plan Option N	
	Tobacco Use*		Tobacco Use*		Tobacco Use*		Tobacco Use*		Tobacco Use*		Tobacco Use*		Tobacco Use*		Tobacco Use*	
	Female	Male	Female	Male	Female	Male	Female	Male								
0 - 64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A								
65	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
66	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
67	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
68	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
69	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
70	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
71	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
72	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
73	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
74	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
75	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
76	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
77	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
78	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
79	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
80	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
81	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
82	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
83	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
84	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
85+	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93

Rate Area	Factor
AR (716-717, 719-722, 724-726, 728)	0.95
AR (718, 723)	1.05
AR (727, 729)	0.85

Mode Factors	
Annual	1.0000
Semiannual	0.5200
Quarterly	0.2700
Special Mo.	0.0875

\* Rates shown are Tobacco User Rates. Rates for Non-Tobacco Users are 90% of the rates shown.

SERFF Tracking Number: ANTX-126515349 State: Arkansas  
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 45265  
 Company Tracking Number:  
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010  
 Product Name: 2010 MEDICARE SUPPLEMENT  
 Project Name/Number: 2010 MEDICARE SUPPLEMENT/2010 MEDICARE SUPPLEMENT

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Accepted for Informational Purposes	04/19/2010

**Comments:**

**Attachments:**

AR Readability Certification.pdf  
 AR Imp Information Notice.pdf

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved	04/19/2010

**Comments:**

**Attachments:**

AR Application.pdf  
 AR APPLICATION ELECTRONIC.pdf

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Outline of Coverage	Approved	04/19/2010

**Comments:**

**Attachment:**

AR Outline.pdf

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> PREVIOUSLY APPROVED REPLACEMENT NOTICE	Accepted for Informational Purposes	04/19/2010

**Comments:**

**Attachment:**

REPLACEMENT NOTICE GENERIC.pdf

SERFF Tracking Number: ANTX-126515349 State: Arkansas  
Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 45265  
Company Tracking Number:  
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010  
Product Name: 2010 MEDICARE SUPPLEMENT  
Project Name/Number: 2010 MEDICARE SUPPLEMENT/2010 MEDICARE SUPPLEMENT

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Rates by Monthly Premium

Approved

04/19/2010

**Comments:**

**Attachments:**

AR Rates by Monthly Premium.pdf

AR Actuarial Memorandum w Rates.pdf



**READABILITY CERTIFICATION**

I, William J. Hogan, an Officer of the Standard Life and Accident Insurance Company, hereby certify that the following forms have the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet or exceed the reading ease requirements of the Statutes and Regulations of your state.

FORM	READABILITY SCORE
2010-1006-AR	50.1
2010-1006-A	50.1
2010-1006-B	50.1
2010-1006-C	50.1
2010-1006-D	50.1
2010-1006-F	50.1
2010-1006-FHD	50.1
2010-1006-G	50.1
2010-1006-N	50.1
MSAPP10AR	50.1
MSAPP10AR-E	50.1
MSOC10AR	50.1
MSB10	50.1

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William J. Hogan  
Asst. Vice President, Health Compliance

03/25/2010

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Date

**IMPORTANT INFORMATION FOR  
ARKANSAS POLICYOWNERS**

If you have questions about your policy or a claim you have filed, please contact your insurance company or your agent:

Standard Life and Accident Insurance Company  
C/O Customer Service Department  
P.O. Box 1820  
Galveston, Texas 77553-1820

Telephone: 1-888-350-1488  
1-409-763-4661

Agent \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

If you are unable to resolve a problem with your insurance company or your agent, you may contact the Arkansas Department of Insurance:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, AR 72201-1804

Telephone: 1-800-852-5494  
1-501-371-2640

E-Mail: [Insurance@mail.state.ar.us](mailto:Insurance@mail.state.ar.us)

Web Site: [www.state.ar.us/insurance](http://www.state.ar.us/insurance)

CCN-AR3

**APPLICATION FOR MEDICARE SUPPLEMENT** *(Please Print - Black Ink)*

**SECTION A**

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

**SECTION B**

- New Policy  Reinstatement
3. **I AM APPLYING FOR:** Medicare Supplement Plan \_\_\_\_\_  
 Male  Female
4. **Payment Mode:**  Annual  Semi-Annual  Quarterly  Monthly PAC
5. **Requested Effective Date:** \_\_\_\_\_
6. **Medicare claim number:** \_\_\_\_\_

**SECTION C**

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

**PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X".**

**To the best of your knowledge:**

7. Did you turn age 65 in the last 6 months?  
 Yes  No
8. Did you enroll in Medicare Part B in the last 6 months?  
 Yes  No  
 If Yes, what is the effective date? \_\_\_\_\_
9. 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.)  
 Yes  No  
 If Yes, will Medicaid pay your premiums for this Medicare Supplement policy?  
 Yes  No  
 If Yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?  
 Yes  No
10. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in

your start and end dates below. If you are still covered under this plan, leave "END" blank.

START \_\_\_\_/\_\_\_\_/\_\_\_\_ END \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Was this your first time in this type of Medicare plan?

Yes  No

Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

Yes  No

11. Do you have another Medicare Supplement policy in force?

Yes  No

If so, with what company, and what plan do you have?

\_\_\_\_\_  
 If so, do you intend to replace your current Medicare Supplement policy with this policy?

Yes  No

**SECTION C (continued)**

12. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan)

- Yes  No

If so, with what company and what kind of policy?

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

START \_\_\_\_/\_\_\_\_/\_\_\_\_ END \_\_\_\_/\_\_\_\_/\_\_\_\_

13. Do you qualify for open enrollment?

- Yes  No

If Yes, please explain.

14. Do you qualify for guarantee issue?

- Yes  No

If Yes, please submit proof with application.

**SECTION D**

**COMPLETE IF APPLYING FOR MEDICARE SUPPLEMENT ON A NON-OPEN ENROLLMENT OR NON-GUARANTEE ISSUE BASIS.**

Non Tobacco User  Tobacco User

Height \_\_\_\_\_ Weight \_\_\_\_\_

**UNDER OPEN ENROLLMENT, HEALTH QUESTIONS ARE NOT REQUIRED TO BE ANSWERED.**

**If the answer to any question in Section D (15-18h) is Yes, the application should not be submitted.**

15. Are you now bedridden, confined to a nursing home, assisted living facility or hospital, or receiving the services of a home health care agency?

- Yes  No

16. Within the past **10 years**, have you been treated for or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection?

- Yes  No

17. Within the past **2 years**, have you:

a) had or been recommended to have medical tests or treatment or surgery which have not been done or for which results have not been given?

- Yes  No

b) been hospitalized 2 or more times or confined to a nursing home or required assistance or supervision by another person for dressing, eating, personal hygiene (bathing or toileting), walking or transferring to or from a bed or chair or suffered a fracture of the spine or hip?

- Yes  No

c) required the use of a wheelchair, walker or cane?

- Yes  No

d) been advised to have cataract surgery or other eye surgery that has not been performed?

- Yes  No

18. Do you now have or within the past **2 years** have you had or been advised to have treatment, surgery or to take prescription medication for:

a) cancer (excluding basal or squamous cell), Hodgkin's disease, leukemia, or melanoma; even if the conditions are in remission?

- Yes  No

b) congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder, heart disease, enlarged heart, transient ischemic attack, stroke, heart or heart valve surgery, angioplasty, pacemaker, or stent placement?

- Yes  No

c) uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene?

- Yes  No

d) emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen?

- Yes  No

e) ulcerative colitis, Crohn's disease, cirrhosis of the liver, hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment?

- Yes  No

f) Paget's disease, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder?

- Yes  No

g) mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders or alcohol or drug abuse?

- Yes  No

h) incontinence, any ostomy present due to disease, an organ transplant other than corneal?

- Yes  No

19. Within the past **2 years**, have you consulted a physician, been diagnosed or received treatment for any condition not listed above, including dizziness, vertigo, tremors, seizures, depression, anxiety, amputation, arthritis, asthma, osteoporosis, urinary incontinence, heart rhythm disorders, heart bypass or heart attack?

- Yes  No

If Yes, give information regarding diagnosis or condition.

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## SECTION E

### NOTICE TO MEDICARE SUPPLEMENT APPLICANT

**The Applicant must read the following statements or the Agent must read the following statements to the Applicant.**

You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare Benefits.

You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. If, after purchasing this coverage, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement coverage 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 coverage (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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 the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

## SECTION F

**AGREEMENT** — I have read or had read to me my completed application (including the statements in Section E). My answers are true and complete. I understand my coverage, if issued, will begin on the date of issue shown in my policy. I realize any false statement or misrepresentation in my application may result in loss of coverage under my policy. If application taken over the phone, I agree that my electronic signature serves as my original signature.

**FRAUD WARNING** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application is guilty of a crime and may be subject to fines and confinement in prison.

**ACKNOWLEDGMENT** — I have received the Outline of Coverage and *Guide to Health Insurance for People with Medicare* from the Agent.

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### A TELEPHONE INTERVIEW WILL BE CONDUCTED.

**What will be the best time to contact the Applicant for the telephone interview?** \_\_\_\_\_

\_\_\_\_\_

# AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

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

I understand that:

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

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

\_\_\_\_\_

Date

\_\_\_\_\_

Applicant's Signature

\_\_\_\_\_

Witness

\_\_\_\_\_

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

## AGENT'S STATEMENT

I certify that: 1) I asked the Applicant the questions in the application and truthfully and accurately recorded the answers; 2) the answers did not conflict with my observations and knowledge of the Applicant; and 3) if applicable, I gave the outline of coverage and *Guide to Health Insurance for People with Medicare* to the Applicant and a copy of the appropriate form(s) and/or disclosure(s).

I also certify that: 1) the Applicant has read, or had read to him or her, the completed application (including the statements in Section E); and 2) the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

The company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant and which are currently in force are (if none, write "NONE"): \_\_\_\_\_

The company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant during the past 5 years and which are not currently in force are (if none, write "NONE"): \_\_\_\_\_

As the Agent, do you have any knowledge or reason to believe that replacement of existing insurance may be involved?...  Yes  No

### AGENT INFORMATION

Name (printed) \_\_\_\_\_ Signature \_\_\_\_\_

Agent Code \_\_\_\_\_ Date Signed \_\_\_\_\_

Email \_\_\_\_\_ Fax \_\_\_\_\_ Phone \_\_\_\_\_

Premium Quoted \$ \_\_\_\_\_

Special Requests: \_\_\_\_\_

Initial Premium \$ \_\_\_\_\_

No money collected. Initial premium is to be drafted.

Receipt Given: Yes  No

Mail Policy to: Insured  Agent

## AUTHORIZATION TO MY BANK

### Bank Information

Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree that should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. If application taken over the phone, I agree that my electronic signature serves as my original signature.

\_\_\_\_\_   
Date Signed

Signature (as it appears on bank records)

Complete if no personalized deposit ticket is available.

Account Number \_\_\_\_\_

Routing Number \_\_\_\_\_

## PREAUTHORIZED CHECK AUTHORIZATION

**Attach Voided Check  
or Deposit Ticket Here  
and Sign Authorization**

Checking

Savings

## RECEIPT

**IF PREMIUM IS COLLECTED, CHECK OR MONEY ORDER FOR INITIAL PREMIUM MUST ACCOMPANY APPLICATION. ALL CHECKS AND MONEY ORDERS MUST BE PAYABLE TO STANDARD LIFE AND ACCIDENT INSURANCE COMPANY.** If a policy is not issued, the initial premium will be refunded to the Applicant. If a policy is issued, coverage will begin on the date of issue shown in the policy.

Received from \_\_\_\_\_ on \_\_\_\_\_ Date

an application for Plan \_\_\_\_\_ and a Check  Money Order  for \$ \_\_\_\_\_

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

Agent's Signature \_\_\_\_\_

## DISCLOSURE NOTICE

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

Medical Information Bureau (MIB) Pre-notification – Information regarding your insurability will be treated as confidential. Standard Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Standard Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

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

**STANDARD LIFE AND ACCIDENT INSURANCE COMPANY • P.O. Box 696870 • San Antonio, Texas 78269 • 888.350.1488**

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**Standard Life and Accident Insurance Company**  
P.O. Box 696870, San Antonio, TX 78269  
888.350.1488



Application ID:  
Policy ID:

Standard Life and Accident Insurance Company  
Medicare Supplement Application • P.O. Box 696870 • San Antonio, Texas 78269

<b>SECTION A</b>		
<b>APPLICANT INFORMATION</b>		
<b>Last Name</b>	<b>First Name</b>	<b>MI</b>
DUCK	DONALD	A
<b>Date Of Birth</b>	<b>Age</b>	
03/20/1942		
<b>Home Address</b>		
123 S MAIN ST		
<b>City</b>	<b>State</b>	<b>Zip Code</b>
DISNEYLAND	CA	55555
<b>Home Phone</b>	<b>Best Time to Call (AM/PM)</b>	<b>Email Address</b>
(876)354-0012	AM	DDUCK@DISNEY.COM
<b>Billing Address (if different)</b>		
N/A		
<b>City</b>	<b>State</b>	<b>Zip Code</b>
N/A	N/A	N/A

<b>SECTION B</b>	
<b>Application Type</b>	
NEW POLICY	
<b>Medicare Supplement Plan</b>	<b>Gender</b>
PLAN B	M
<b>Payment Mode</b>	
QUARTERLY	
<b>Requested Effective Date</b>	
01/01/2010	
<b>Medicare claim number</b>	
123-23-1234A	

**SECTION C**

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

**To the best of your knowledge:**

7. Did you turn 65 in the last 6 months? YES

8. Did you enroll in Medicare Part B in the last 6 months? YES  
If Yes, what is the effective date? 01/01/2010

9. Are you covered for medical assistance through the state Medicaid program? YES  
(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, will Medicaid pay your premiums for this Medicare Supplement policy? YES

If Yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? YES

10. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START: 12/01/2001 END: 01/01/2010

If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? YES

Was this your first time in this type of Medicare plan? YES

Did you drop a Medicare Supplement policy to enroll in the Medicare plan? YES

11. Do you have another Medicare Supplement policy in force? YES

If so, with what company, and what plan do you have?

GENERAL MEDICAL INSURANCE

If so, do you intend to replace your current Medicare Supplement policy with this policy? YES

12. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) YES

If so, with what company and what kind of policy?

GENERAL MEDICAL INSURANCE WHOLE HEALTH

What are your dates of coverage under the other policy?

If you are still covered under the other policy, leave "END" blank.

START: 12/01/2009 END: 01/01/2010

13. Do you qualify for open enrollment? YES

If Yes, please explain.

I HAVE REACHED MY 65TH BIRTHDAY

14. Do you qualify for guarantee issue? YES

If Yes, please submit proof with application.

**SECTION D**

**COMPLETE IF APPLYING FOR MEDICARE SUPPLEMENT ON A NON-OPEN ENROLLMENT OR NON-GUARANTEE ISSUE BASIS.**

Tobacco Use: TOBACCO USER

Height: 5'10" Weight: 195

**UNDER OPEN ENROLLMENT, HEALTH QUESTIONS ARE NOT REQUIRED TO BE ANSWERED.**

**If the answer to any question in Section D (15-18h) is Yes, the application should not be submitted.**

15. Are you now bedridden, confined to a nursing home, assisted living facility or hospital, or receiving the services of a home health care agency? YES
- 
16. Within the past **10 years**, have you been treated for or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection? YES
- 
17. Within the past **2 years**, have you:
- 17a. had or been recommended to have medical tests or treatment or surgery which have not been done or for which results have not been given? YES
- 
- 17b. been hospitalized 2 or more times or confined to a nursing home or required assistance or supervision by another person for dressing, eating, personal hygiene (bathing or toileting), walking or transferring to or from a bed or chair or suffered a fracture of the spine or hip? YES
- 
- 17c. required the use of a wheelchair, walker or cane? YES
- 
- 17d. been advised to have cataract surgery or other eye surgery that has not been performed? YES
- 
18. Do you now have or within the past **2 years** have you had or been advised to have treatment, surgery or to take prescription medication for:
- 18a. cancer (excluding basal or squamous cell), Hodgkin's disease, leukemia, or melanoma; even if the conditions are in remission? YES
- 
- 18b. congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder, heart disease, enlarged heart, transient ischemic attack, stroke, heart or heart valve surgery, angioplasty, pacemaker, or stent placement? YES
- 
- 18c. uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene? YES
- 
- 18d. emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen? YES
- 
- 18e. ulcerative colitis, Crohn's disease, cirrhosis of the liver, hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment? YES
-

**SECTION D (continued)**

18f. Paget's disease, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder? YES

18g. mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders or alcohol or drug abuse? YES

18h. incontinence, any ostomy present due to disease, an organ transplant other than corneal? YES

19. Within the past **2 years**, have you consulted a physician, been diagnosed or received treatment for any condition not listed above, including dizziness, vertigo, tremors, seizures, depression, anxiety, amputation, arthritis, asthma, osteoporosis, urinary incontinence, heart rhythm disorders, heart bypass or heart attack? YES

If Yes, give information regarding diagnosis or condition.

**Date of treatment From:** 12/06  
**Date of treatment To:** 10/07  
**Reason for Check-up, Diagnosis, Illness or Frequency of Attacks:** SORENESS IN FOOT  
**Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery:** GOUT, MEDICATION, COMPLETE RECOVERY  
**Name and Address of Each Physician, Practitioner, and Medical Facility:** DR. NIGLE HONEYCUT, 123 IMAGINATION BLVD, EPCOT, FL 22222

**SECTION E**

**NOTICE TO MEDICARE SUPPLEMENT APPLICANT**

**The Applicant must read the following statements or the Agent must read the following statements to the Applicant.**

You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare Benefits.

You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. If after purchasing this coverage, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement coverage 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 coverage (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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 the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

**SECTION F**

**AGREEMENT** - I have read or had read to me my completed application (including the statements in Section E). My answers are true and complete. I understand my coverage, if issued, will begin on the date of issue shown in my policy. I realize any false statement or misrepresentation in my application may result in loss of coverage under my policy. If application taken over the phone, I agree that my electronic signature serves as my original signature.

**FRAUD WARNING** - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**ACKNOWLEDGMENT** - I have received the Outline of Coverage and *Guide to Health Insurance for People with Medicare* from the Agent.

**I agree that my electronic signature on this Enrollment Application serves as my original signature.**

**Applicant's Signature**

<b>First Name :</b>	DONALD	<b>Last Name:</b>	DUCK	<b>Date:</b>	01/20/2010
<b>City :</b>	DISNEYLAND	<b>State:</b>	CA	<b>Zip:</b>	55555



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

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

I understand that:

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

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

**I agree that my electronic signature serves as my original signature.**

**Applicant's Signature**

<b>First Name :</b>	DONALD	<b>Last Name:</b>	DUCK	<b>Date:</b>	01/20/2010
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<b>Witness :</b>	SNUFFY SMITH
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<b>Personal Representative :</b>	N/A
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**AGENT'S STATEMENT**

I certify that: 1) I asked the Applicant the questions in the application and truthfully and accurately recorded the answers; 2) the answers did not conflict with my observations and knowledge of the Applicant; and 3) if applicable, I gave the outline of coverage and *Guide to Health Insurance for People with Medicare* to the Applicant and a copy of the appropriate form(s) and/or disclosure(s).

I also certify that: 1) the Applicant has read, or had read to him or her, the completed application (including the statements in Section E); and 2) the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

The company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant and which are currently in force are (if none, write "NONE"):

The company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant during the past 5 years and which are not currently in force are (if none, write "NONE"):

As the agent, do you have any knowledge or reason to believe that replacement of existing insurance may be involved?

**Agent Information**

**First Name:**  **Last Name:**

**Agent Code:**  **Date Signed:**

**Phone:**  **Fax# :**  **Email:**

**Premium Quoted:**  **Initial Premium :**

**No money collected. Initial premium is to be drafted.** YES

**Receipt Given:** YES

**Mail Policy to:** INSURED

**Special Requests:**

THERE ARE NO SPECIAL INSTRUCTIONS

## DISCLOSURE NOTICE

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

Medical Information Bureau (MIB) Pre-notification - Information regarding your insurability will be treated as confidential. Standard Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901(TTY 866.346.3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Standard Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

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

**STANDARD LIFE AND ACCIDENT INSURANCE COMPANY • P.O. Box 696870 • San Antonio, Texas 78269 • 888.350.1488**



**Standard Life and Accident Insurance Company**

P.O. Box 696820  
San Antonio, TX 78269  
888.350.1488

**Outline of Medicare Supplement Coverage**

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

**2010**

**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	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 \$[4,620]; paid at 100% after limit reached	Out-of-pocket limit \$[2,310]; paid at 100% after limit reached		
<b>Policy Form 2010-1006 Plan A</b>	<b>Policy Form 2010-1006 Plan B</b>	<b>Policy Form 2010-1006 Plan C</b>	<b>Policy Form 2010-1006 Plan D</b>	<b>Policy Form 2010-1006 Plan F</b>	<b>Policy Form 2010-1006 Plan F(HD)</b>	<b>Policy Form 2010-1006 Plan G</b>				<b>Policy Form 2010-1006 Plan N</b>

\*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.

**ARKANSAS PREMIUMS FOR ZIP CODES (727, 729)**

<b>2010</b>		<b>PLAN A RATES</b>							<b>2010</b>
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>				
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	
65 and Older	[\$2,258.81]	[\$1,174.58]	[\$609.88]	[\$197.65]	[\$2,509.79]	[\$1,305.09]	[\$677.64]	[\$219.61]	

<b>PLAN B RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,571.84]	[\$1,1337.36]	[\$694.40]	[\$225.04]	[\$2,857.60]	[\$1,485.95]	[\$771.55]	[\$250.04]

<b>PLAN C RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,923.98]	[\$1,520.47]	[\$789.47]	[\$255.85]	[\$3,248.87]	[\$1,689.41]	[\$877.19]	[\$284.28]

<b>PLAN D RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,761.89]	[\$916.18]	[\$475.71]	[\$154.17]	[\$1,957.65]	[\$1,017.98]	[\$528.57]	[\$171.29]

<b>PLAN F RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,404.52]	[\$1,250.35]	[\$649.22]	[\$210.40]	[\$2,671.69]	[\$1,389.28]	[\$721.36]	[\$233.77]

<b>PLAN F (HIGH DEDUCTIBLE) RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$349.65]	[\$181.82]	[\$94.41]	[\$30.59]	[\$388.49]	[\$202.01]	[\$104.89]	[\$33.99]

<b>PLAN G RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,775.34]	[\$923.18]	[\$479.34]	[\$155.34]	[\$1,972.60]	[\$1,025.75]	[\$532.60]	[\$172.60]

<b>PLAN N RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,159.69]	[\$603.04]	[\$313.12]	[\$101.47]	[\$1,288.54]	[\$670.04]	[\$347.91]	[\$112.75]

**ARKANSAS PREMIUMS FOR ZIP CODES (716-717, 719-722, 724-726, 728)**

<b>2010</b>		<b>PLAN A RATES</b>							<b>2010</b>
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>				
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	
65 and Older	[\$2,524.55]	[\$1,312.77]	[\$681.63]	[\$220.90]	[\$2,805.06]	[\$1,458.63]	[\$757.37]	[\$245.44]	

<b>PLAN B RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,874.41]	[\$1,494.69]	[\$776.09]	[\$251.51]	[\$3,193.79]	[\$1,660.77]	[\$862.32]	[\$279.46]

<b>PLAN C RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$3,267.98]	[\$1,699.35]	[\$882.35]	[\$285.95]	[\$3,631.09]	[\$1,888.17]	[\$980.36]	[\$317.72]

<b>PLAN D RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,969.17]	[\$1,023.97]	[\$531.68]	[\$172.30]	[\$2,187.96]	[\$1,137.74]	[\$590.75]	[\$191.45]

<b>PLAN F RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,687.41]	[\$1,397.45]	[\$725.60]	[\$235.15]	[\$2,986.01]	[\$1,552.73]	[\$806.22]	[\$261.28]

<b>PLAN F (HIGH DEDUCTIBLE) RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$390.78]	[\$203.21]	[\$105.51]	[\$34.19]	[\$434.20]	[\$225.78]	[\$117.23]	[\$37.99]

<b>PLAN G RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,984.20]	[\$1,031.78]	[\$535.73]	[\$173.62]	[\$2,204.67]	[\$1,146.43]	[\$595.26]	[\$192.91]

<b>PLAN N RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,296.12]	[\$673.98]	[\$349.95]	[\$113.41]	[\$1,440.13]	[\$748.87]	[\$388.84]	[\$126.01]

**ARKANSAS PREMIUMS FOR ZIP CODES (718, 723)**

<b>2010</b>		<b>PLAN A RATES</b>							<b>2010</b>
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>				
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	
65 and Older	[\$2,790.29]	[\$1,450.95]	[\$753.98]	[\$244.15]	[\$3,100.32]	[\$1,612.17]	[\$837.09]	[\$271.28]	

<b>PLAN B RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$3,176.97]	[\$1,652.02]	[\$857.78]	[\$277.98]	[\$3,529.97]	[\$1,835.58]	[\$953.09]	[\$308.87]

<b>PLAN C RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$3,611.98]	[\$1,878.23]	[\$975.23]	[\$316.05]	[\$4,013.31]	[\$2,086.92]	[\$1,083.59]	[\$351.16]

<b>PLAN D RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,176.45]	[\$1,137.75]	[\$587.64]	[\$190.44]	[\$2,418.28]	[\$1,257.51]	[\$652.94]	[\$211.60]

<b>PLAN F RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,970.29]	[\$1,544.55]	[\$801.98]	[\$259.90]	[\$3,300.33]	[\$1,716.17]	[\$891.09]	[\$288.78]

<b>PLAN F (HIGH DEDUCTIBLE) RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$431.92]	[\$224.60]	[\$116.62]	[\$37.79]	[\$479.90]	[\$249.55]	[\$129.57]	[\$41.99]

<b>PLAN G RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$2,193.06]	[\$1,140.39]	[\$592.13]	[\$191.89]	[\$2,436.74]	[\$1,267.10]	[\$657.92]	[\$213.21]

<b>PLAN N RATES</b>								
<b>Issue Age</b>	<b>Non Tobacco User</b>				<b>Tobacco User</b>			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65 and Older	[\$1,432.56]	[\$744.93]	[\$386.79]	[\$125.35]	[\$1,591.73]	[\$827.70]	[\$429.77]	[\$139.28]

## **PREMIUM INFORMATION**

We, Standard Life and Accident Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state.

## **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 your insurance company.

## **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to:

Standard Life and Accident  
Insurance Company  
P.O. Box 696820  
San Antonio, TX 78269

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 Standard Life 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. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

**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.

<b>PLAN A</b>			
<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	\$0 [\$275] a day [\$550] a day 100% of Medicare Eligible Expenses \$0	[\$1,100] (Part A Deductible) \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$137.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs inpatient respite care	Medicare copayment/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 an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**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.

**PLAN A**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> 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
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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
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**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.

**PLAN B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days  61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days  — Beyond the Additional 365 days	All but [\$1,100]  All but [\$275] a day  All but [\$550] a day  \$0  \$0	[\$1,100] (Part A Deductible)  [\$275] a day  [\$550] a day  100% of Medicare Eligible Expenses  \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$137.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

**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.

**PLAN B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> 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
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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
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**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.

**PLAN C**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies:</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <p>— While using 60 lifetime reserve days</p> <p>— Once lifetime reserve days are used:</p> <p>— Additional 365 days</p> <p>— Beyond the Additional 365 days</p>	<p>All but [\$1,100]</p> <p>All but [\$275] a day</p> <p>All but [\$550] a day</p> <p>\$0</p> <p>\$0</p>	<p>[\$1,100] (Part A Deductible)</p> <p>[\$275] a day</p> <p>[\$550] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>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>Up to [\$137.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>

**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.

**PLAN C**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES —</b> 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%	[\$155] (Part B Deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next [\$155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs [\$155] (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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 [\$155] (Part B Deductible) 20%	\$0 \$0 \$0
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**OTHER BENEFITS — NOT COVERED BY MEDICARE**

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

**PLAN D**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 Up to [\$137.50] a day \$0	\$0 \$0 All costs

**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.

**PLAN D**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> 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
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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
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## OTHER BENEFITS — NOT COVERED BY MEDICARE

## PLAN D

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

**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.

**PLAN F**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 Up to [\$137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs inpatient respite care	Medicare copayment/coinsurance	\$0

**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.

**PLAN F**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> 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%	[\$155] (Part B Deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs [\$155] (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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 [\$155] (Part B Deductible) 20%	\$0 \$0 \$0
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**OTHER BENEFITS — NOT COVERED BY MEDICARE**

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

† This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

**PLAN F (HIGH DEDUCTIBLE)**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY [\$2,000] DEDUCTIBLE† PLAN PAYS</b>	<b>IN ADDITION TO [\$2,000] DEDUCTIBLE† YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 Up to [\$137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

**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.

† This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

**PLAN F (HIGH DEDUCTIBLE)**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY [\$2,000] DEDUCTIBLE† PLAN PAYS</b>	<b>IN ADDITION TO [\$2,000] DEDUCTIBLE† YOU PAY</b>
<b>MEDICAL EXPENSES —</b> 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%	[\$155] (Part B Deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs [\$155] (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**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.

† This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.

**PARTS A & B**

**PLAN F (HIGH DEDUCTIBLE)**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2,000] DEDUCTIBLE† PLAN PAYS	IN ADDITION TO [\$2,000] DEDUCTIBLE† YOU PAY
<b>HOME HEALTH CARE</b> 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 BENEFITS — NOT COVERED BY MEDICARE**

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

**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.

**PLAN G**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days  61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days  — Beyond the Additional 365 days	All but [\$1,100]  All but [\$275] a day  All but [\$550] a day  \$0  \$0	[\$1,100] (Part A Deductible)  [\$275] a day  [\$550] a day  100% of Medicare Eligible Expenses  \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 Up to [\$137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

**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.

**PLAN G**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> 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%	\$0 \$0 [\$155] (Part B Deductible)
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$0 \$0 [\$155] (Part B Deductible)
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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 \$0 \$0 [\$155] (Part B Deductible)
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## OTHER BENEFITS — NOT COVERED BY MEDICARE

## PLAN G

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

**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.

**PLAN N**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days  61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days  — Beyond the Additional 365 days	All but [\$1,100]  All but [\$275] a day  All but [\$550] a day  \$0  \$0	[\$1,100] (Part A Deductible)  [\$275] a day  [\$550] a day  100% of Medicare Eligible Expenses  \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$137.50] a day \$0	\$0 Up to [\$137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs inpatient respite care	Medicare copayment/coinsurance	\$0

**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.

**PLAN N**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES —</b> 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 Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment 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.	[\$155] (Part B Deductible) Up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment 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.
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**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.

**PARTS A & B**

**PLAN N**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b>			
<b>MEDICARE APPROVED SERVICES</b>			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First [\$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**

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

<b>2010 Index</b> <b>Arkansas Medicare Supplement</b>
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Zip Codes	Rates (Page #)	Plan Description (Page #)
<b>Plan A</b>		6-7
727, 729	2	
716-717, 719-722, 724-726, 728	3	
718, 723	4	
<b>Plan B</b>		8-9
727, 729	2	
716-717, 719-722, 724-726, 728	3	
718, 723	4	
<b>Plan C</b>		10-11
727, 729	2	
716-717, 719-722, 724-726, 728	3	
718, 723	4	
<b>Plan D</b>		12-14
727, 729	2	
716-717, 719-722, 724-726, 728	3	
718, 723	4	
<b>Plan F</b>		15-16
727, 729	2	
716-717, 719-722, 724-726, 728	3	
718, 723	4	
<b>Plan F(HD)</b>		17-19
727, 729	2	
716-717, 719-722, 724-726, 728	3	
718, 723	4	
<b>Plan G</b>		20-22
727, 729	2	
716-717, 719-722, 724-726, 728	3	
718, 723	4	
<b>Plan N</b>		23-25
727, 729	2	
716-717, 719-722, 724-726, 728	3	
718, 723	4	
Summary of Benefits by Plan		1
Premium Information and Disclosures		5

**NOTICE TO APPLICANT REGARDING REPLACEMENT  
 OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE  
 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 Standard Life and Accident 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.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. \_\_\_\_\_
- Other (please specify). \_\_\_\_\_

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 you want to keep it.

\_\_\_\_\_  
 Agent's Signature

\_\_\_\_\_  
 Print Name and Address of Agent

The above "Notice to Applicant" was delivered to me on: \_\_\_\_\_  
Date

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

Standard Life and Accident Insurance Company  
Form 2010-1006 Monthly PAC Rates

AR (716-717, 719-722, 724-726, 728)

Attained Age	Plan A				Plan B				Plan C				Plan D				Plan F				Plan F(hd)				Plan G				Plan N			
	Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male	
	NTU	TU	NTU	TU	NTU	TU	NTU	TU	NTU	TU	NTU	TU																				
65+	220.90	245.44	220.90	245.44	251.51	279.46	251.51	279.46	285.95	317.72	285.95	317.72	172.30	191.45	172.30	191.45	235.15	261.28	235.15	261.28	34.19	37.99	34.19	37.99	173.62	192.91	173.62	192.91	113.41	126.01	113.41	126.01

AR (718, 723)

Attained Age	Plan A				Plan B				Plan C				Plan D				Plan F				Plan F(hd)				Plan G				Plan N			
	Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male	
	NTU	TU	NTU	TU	NTU	TU	NTU	TU	NTU	TU	NTU	TU																				
65+	244.15	271.28	244.15	271.28	277.98	308.87	277.98	308.87	316.05	351.16	316.05	351.16	190.44	211.60	190.44	211.60	259.90	288.78	259.90	288.78	37.79	41.99	37.79	41.99	191.89	213.21	191.89	213.21	125.35	139.28	125.35	139.28

AR (727, 729)

Attained Age	Plan A				Plan B				Plan C				Plan D				Plan F				Plan F(hd)				Plan G				Plan N			
	Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male	
	NTU	TU	NTU	TU	NTU	TU	NTU	TU	NTU	TU	NTU	TU																				
65+	197.65	219.61	197.65	219.61	225.04	250.04	225.04	250.04	255.85	284.28	255.85	284.28	154.17	171.29	154.17	171.29	210.40	233.77	210.40	233.77	30.59	33.99	30.59	33.99	155.34	172.60	155.34	172.60	101.47	112.75	101.47	112.75

## Actuarial Certification

The anticipated loss ratio over the policy lifetime as well as in the third policy year is expected to be not less than 65%. This equals the minimum loss ratio requirement for group Medicare Supplement policies. This estimate is based on a projection of financial results.

Loss ratio, as used in this memorandum, means the present value of incurred claims divided by the present value of earned premiums.

To the best of my knowledge and belief:

- a) this filing is in compliance with the applicable laws and regulations of the state and is in compliance with the current standards of practice as promulgated by the Actuarial Standards Board.
- b) the benefits provided are reasonable in relation to the premiums charged; and
- c) the assumptions appropriately represent the expected values.



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Michael Shumate, ASA  
Health Actuary  
One Moody Plaza  
Galveston TX 77550-7999  
(281) 538-4827

3/23/2010

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Date

## Information Sheet

### I. Purpose

This actuarial memorandum is intended to support the initial filing of premium rates for Standard Life and Accident Insurance Company (SLAICO) Standardized Medicare Supplement Form 2010 and Plan Options A, B, C, D, F, F(hd), G and N. It is not intended for any other use or purpose.

### II. Renewability Provision

Form 2010 is Guaranteed Renewable. SLAICO reserves the right to change the premiums if such change applies to all policies in the same state of issue.

### III. Premium Rate Basis

Premiums rates vary by the requirements of the state of issue and will be either attained age, issue age or community rated, as each state requires. This memorandum is for Arkansas only. Plan Options are available to applicants aged 65 and over.

### IV. Underwriting

Open enrollment is available to persons who submit an application for this form during the six month period beginning with the first month in which the person attains the age of 65 or other state and/or federal specific requirements.

If the applicant is eligible for open enrollment, this form does not discriminate in pricing because of their health status, claims experience, receipt of health care or medical condition.

If the applicant is not eligible for open enrollment, home office underwriting is performed. There is no pre-existing limitation under this form in any case.

### V. Form Availability

This form will be available in your state upon receipt of approval and release by the home office. Release will be conditioned on any state requirements and the availability of marketing materials, if any.

This is a new form. It does not replace any existing form.

### VI. Benefits

Form 2010 offers Standardized Medicare Supplement Plan Options A, B, C, D, F, F(hd), G and N. Benefits are determined by the Plan Option chosen by the policyholder. Benefits and services covered are described in the 2010 NAIC Medicare Supplement Insurance Model Regulation. This form does not contain any innovative benefit as described in the regulation.

Standard Life and Accident Insurance Company  
Actuarial Memorandum for Medicare Supplement Policy Form 2010-1006  
(Referred to as Form 2010 in this memorandum)

**VII. Refund or Credit of Premium**

If, on the basis of experience reported, the benchmark loss ratio since inception exceeds the adjusted experience loss ratio since inception on a statewide basis for this form, then a refund or credit of premium will be given. The benchmark loss ratio is calculated via assumptions specified in the NAIC Medicare Supplement Insurance Model Regulation.

Any such refund would include interest from the end of the calendar year to the date of the refund or credit.

**VIII. Gross Annual Premiums and Area Factors**

Gross Annual Premiums, Area Factors and Rating Methodology by state are attached.

## Actuarial Assumptions

### 1. Method of Calculation

Premiums were calculated using a calendar year profit study. Such calculations were based on the present value of premiums, claims, expenses, commissions and investment income. The assumptions used are shown below. Incurred claims are calculated from paid claims plus the change in the claim reserve. Earned premium are calculated as the collected premium plus the change in unearned premium reserve.

### 2. Morbidity Basis

Average claim costs were based on studies of the company's own experience and actuarial judgement, supplemented with data supplied by Milliman & Robertson, Inc. from their Health Cost Guidelines for Ages 65 and Over.

Sample claim costs are shown in Exhibit I.

### 3. Effect of Initial Selection

Initial selection varies by issue class:

Duration	Selection Factors		
	Under-written	Open Enrollment	Guaranteed Issue
1	0.7255	0.8644	1.2136
2	0.8180	0.8225	1.2954
3	0.8200	0.8225	1.3359
4	0.8200	0.8225	1.3378
5+	0.8200	0.8225	1.3378
Issue Age	Distribution		
65	5.3%	93.8%	0.9%
66+	81.9%	6.3%	11.8%

### 4. Reserve Basis

Statutory Additional Reserves (policy reserves), where necessary, will be based on pricing claims costs, 2001 CSO mortality and interest rates determined by state law. An appropriate statutory margin will be applied to the claims costs. Policy reserves were not considered in calculating the loss ratios for this filing.

Standard Life and Accident Insurance Company  
 Actuarial Memorandum for Medicare Supplement Policy Form 2010-1006  
 (Referred to as Form 2010 in this memorandum)

5. Total Decrement Rates

Total Decrement Rates are shown in Exhibit II, attached to this memorandum. Mortality assumptions are 1991 US Population, extended with 105% of 2001 CSO Composite rates to age 120 (40% Males, 60% Females). Lapse rates are based on the experience of similar plans and judgment. Since there are no mortality-based benefits, mortality and lapse rates are not shown separately. Mortality is defined separately to facilitate calculation of shock lapse for future rate action filings.

6. Experience Base for Future Rate Adjustments

Future rate adjustments will be based on a review of actual experience of this policy form by state, to the extent credible. Nationwide experience and other relevant experience will also be considered to supplement such information. Trends and other variables affecting experience will be recognized in calculating future rate adjustments.

7. Commissions

Guaranteed Issue:                      5% All Years

All Other:

Issue Age	Policy Years	
	1 - 6	7+
65+	16.5%	5.0%

Commissions are a percentage of original premium, less the Part B Deductible premium (\$151 for 2010). Commissions may vary by state as the result of specific state requirements.

8. Other Percentage Expenses

Description of Percentage Expenses	Policy Years	
	1	2+
Premium Taxes and other percentage of premium expenses	29.4%	2.8%
Claims Expenses (Percentage of Incurred Claims)	5.5%	5.5%

9. Per Policy Expenses

Description of Per Policy Expenses	Amount
Issue and Underwriting Expense (At Issue)	\$153.53
Maintenance Expense (every policy year)	\$86.36

Standard Life and Accident Insurance Company  
 Actuarial Memorandum for Medicare Supplement Policy Form 2010-1006  
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10. Expected Modal Distribution and Modal Factors

Mode	Distribution	Factor
Annual	45.0%	1.0000
Semiannual	11.0%	0.5200
Quarterly	4.0%	0.2700
Special Monthly (Check-O-Matic)	40.0%	0.0875

11. Interest Rate for Determining Present Values

An interest rate of 5.5% per annum for all years.

12. Expected Distribution of Business by Age

Issue Age	Distribution by Issue Age
65	28.6%
66-69	18.7%
70-74	24.6%
75-79	15.2%
80-84	6.2%
85+	6.7%

13. Expected Distribution by Gender and Tobacco Use

Gender	Distribution
Female	60.0%
Male	40.0%

Tobacco Use	Distribution
Non-Tobacco User	90.0%
Tobacco User	10.0%

14. Expected Distribution of Business by Plan Option

Plan Option	Distribution by Plan Option
A	0.9%
B	0.6%
C	6.2%
D	20.2%
F	24.3%
F(hd)	9.1%
G	36.5%
N	2.2%

15. Average Annual Premium per Policy

The average annual premium is expected to be \$2,185 per policy at issue before application of area factors.

## Exhibit I

### Sample Average Annual Claim Costs

<b>Attained Age</b>	<b>Average Annual Claim Costs</b>
65	1,506
67	1,467
72	1,463
77	1,546
82	1,634
87	1,727
92	1,825
97	1,929
102	1,994

The sample claim costs are shown without selection adjustments, for states with a 1.0 area factor.

Standard Life and Accident Insurance Company  
 Actuarial Memorandum for Medicare Supplement Policy Form 2010-1006  
 (Referred to as Form 2010 in this memorandum)

## Exhibit II

### Total Decrement Rates

Duration	Issue Age						
	65	67	72	77	82	87	92
1	0.1307	0.1307	0.1307	0.1307	0.1307	0.1727	0.2290
2	0.1757	0.1757	0.1757	0.1757	0.1757	0.1757	0.2395
3	0.1990	0.1990	0.1990	0.1990	0.1990	0.1990	0.2710
4	0.1978	0.1978	0.1978	0.1978	0.1978	0.1978	0.2817
5	0.1763	0.1763	0.1763	0.1763	0.1878	0.2390	0.3266
6	0.1572	0.1572	0.1572	0.1572	0.1979	0.2566	0.3397
7	0.1401	0.1401	0.1401	0.1631	0.2082	0.2735	0.3468
8	0.1251	0.1298	0.1444	0.1698	0.2183	0.2925	0.3619
9	0.1274	0.1322	0.1493	0.1781	0.2283	0.3127	0.3836
10	0.1298	0.1349	0.1545	0.1878	0.2390	0.3303	0.4084
11	0.1322	0.1381	0.1600	0.1979	0.2566	0.3397	0.4370
12	0.1349	0.1419	0.1659	0.2082	0.2735	0.3468	0.4699
13	0.1381	0.1462	0.1725	0.2183	0.2925	0.3619	0.5082
14	0.1419	0.1510	0.1808	0.2283	0.3127	0.3836	0.5536
15	0.1462	0.1563	0.1905	0.2390	0.3303	0.4084	0.6079
16	0.1510	0.1618	0.2006	0.2566	0.3397	0.4370	0.6726
17	0.1563	0.1676	0.2109	0.2735	0.3468	0.4699	0.7487
18	0.1618	0.1743	0.2209	0.2925	0.3619	0.5082	0.8308
19	0.1676	0.1826	0.2308	0.3127	0.3836	0.5536	0.8952
20	0.1743	0.1922	0.2431	0.3303	0.4084	0.6079	0.9310
21	0.1826	0.2022	0.2566	0.3397	0.4370	0.6726	0.9518
22	0.1922	0.2125	0.2735	0.3468	0.4699	0.7487	0.9654
23	0.2022	0.2226	0.2925	0.3619	0.5082	0.8308	0.9737
24	0.2125	0.2324	0.3127	0.3836	0.5536	0.8952	0.9790
25	0.2226	0.2431	0.3303	0.4084	0.6079	0.9310	0.9834
26	0.2324	0.2566	0.3397	0.4370	0.6726	0.9518	0.9879
27	0.2431	0.2735	0.3468	0.4699	0.7487	0.9654	0.9923
28	0.2566	0.2925	0.3619	0.5082	0.8308	0.9737	0.9973
29	0.2735	0.3127	0.3836	0.5536	0.8952	0.9790	1.0000
30	0.2925	0.3303	0.4084	0.6079	0.9310	0.9834	
31	0.3127	0.3397	0.4370	0.6726	0.9518	0.9879	
32	0.3303	0.3468	0.4699	0.7487	0.9654	0.9923	
33	0.3397	0.3619	0.5082	0.8308	0.9737	0.9973	
34	0.3468	0.3836	0.5536	0.8952	0.9790	1.0000	
35	0.3619	0.4084	0.6079	0.9310	0.9834		
36	0.3836	0.4370	0.6726	0.9518	0.9879		
37	0.4084	0.4699	0.7487	0.9654	0.9923		
38	0.4370	0.5082	0.8308	0.9737	0.9973		
39	0.4699	0.5536	0.8952	0.9790	1.0000		

Standard Life and Accident Insurance Company  
 Actuarial Memorandum for Medicare Supplement Policy Form 2010-1006  
 (Referred to as Form 2010 in this memorandum)

**Exhibit II**  
 Total Decrement Rates (Con't)

Duration	Issue Age						
	65	67	72	77	82	87	92
40	0.5082	0.6079	0.9310	0.9834			
41	0.5536	0.6726	0.9518	0.9879			
42	0.6079	0.7487	0.9654	0.9923			
43	0.6726	0.8308	0.9737	0.9973			
44	0.7487	0.8952	0.9790	1.0000			
45	0.8308	0.9310	0.9834				
46	0.8952	0.9518	0.9879				
47	0.9310	0.9654	0.9923				
48	0.9518	0.9737	0.9973				
49	0.9654	0.9790	1.0000				
50	0.9737	0.9834					
51	0.9790	0.9879					
52	0.9834	0.9923					
53	0.9879	0.9973					
54	0.9923	1.0000					
55	0.9973						
56	1.0000						

### Exhibit III Expected Durational Loss Ratios

Year from Issue	Earned Premium	Incurred Claims	Loss Ratio
1	2,185	1,340	61%
2	2,087	1,338	64%
3	1,858	1,207	65%
4	1,578	1,048	66%
5	1,367	912	67%
6	1,213	816	67%
7	1,098	744	68%
8	1,008	689	68%
9	929	641	69%
10	854	593	70%
11	781	547	70%
12	710	501	71%
13	644	458	71%
14	580	416	72%
15	520	375	72%
16	463	337	73%
17	410	300	73%
18	360	265	74%
19	314	233	74%
20	272	203	75%
Lifetime*	14,642	9,774	67%

\* Calculated as the Present Value of Earned Premium and Incurred Claims at 5.5%.  
 Claims trend of 10% grading to 8% was used. Premium increases matched trend.

**EXHIBIT IV**  
**Standard Life and Accident Insurance Company**  
**Policy Form 2010-1006-AR**  
**Base Annual Premium Rates**

Community	Plan Option A		Plan Option B		Plan Option C		Plan Option D		Plan Option F		Plan Option F(hd)		Plan Option G		Plan Option N	
	Tobacco Use*		Tobacco Use*		Tobacco Use*		Tobacco Use*		Tobacco Use*		Tobacco Use*		Tobacco Use*		Tobacco Use*	
	Female	Male	Female	Male	Female	Male	Female	Male								
0 - 64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A								
65	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
66	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
67	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
68	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
69	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
70	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
71	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
72	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
73	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
74	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
75	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
76	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
77	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
78	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
79	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
80	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
81	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
82	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
83	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
84	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93
85+	2,952.69	2,952.69	3,361.88	3,361.88	3,822.20	3,822.20	2,303.12	2,303.12	3,143.17	3,143.17	457.05	457.05	2,320.70	2,320.70	1,515.93	1,515.93

Rate Area	Factor
AR (716-717, 719-722, 724-726, 728)	0.95
AR (718, 723)	1.05
AR (727, 729)	0.85

Mode Factors	
Annual	1.0000
Semiannual	0.5200
Quarterly	0.2700
Special Mo.	0.0875

\* Rates shown are Tobacco User Rates. Rates for Non-Tobacco Users are 90% of the rates shown.