

SERFF Tracking Number: IADC-126565177 State: Arkansas  
Filing Company: Madison National Life Insurance Company Inc State Tracking Number: 45306  
Company Tracking Number: MNL HEARING AID RIDER  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO  
Product Name: Act 1179 Compliance - Hearing Aids  
Project Name/Number: /

## Filing at a Glance

Company: Madison National Life Insurance Company Inc

Product Name: Act 1179 Compliance - Hearing Aids SERFF Tr Num: IADC-126565177 State: Arkansas

Aids

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- Closed State Tr Num: 45306

Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: MNL HEARING AID RIDER State Status: Approved-Closed

Filing Type: Form

Author: Shellie Howard

Date Submitted: 03/30/2010

Reviewer(s): Rosalind Minor

Disposition Date: 05/19/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type:

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 05/19/2010

Explanation for Other Group Market Type:

State Status Changed: 05/19/2010

Deemer Date:

Created By: Shellie Howard

Submitted By: Shellie Howard

Corresponding Filing Tracking Number:

Filing Description:

Hearing aid benefit rider to comply with Act 1179 and bulletin 7A-2009. Please see cover letter for additional details.

## Company and Contact

### Filing Contact Information

Shellie Howard, Forms Development &  
Compliance Specialist

howards@iacusa.com

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2101 W. Peoria Ave 602-861-6070 [Phone]  
 Suite 100  
 Phoenix, AZ 85029-4925

**Filing Company Information**

Madison National Life Insurance Company Inc CoCode: 65781 State of Domicile: Wisconsin  
 1241 John Q Hammons Drive Group Code: 450 Company Type: Life and Health  
 Madison, WI 53717 Group Name: State ID Number:  
 (608) 830-2000 ext. [Phone] FEIN Number: 39-0990296

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$40.00  
 Retaliatory? No  
 Fee Explanation: \$20 per form  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Madison National Life Insurance Company Inc	\$40.00	03/30/2010	35266357
Madison National Life Insurance Company Inc	\$60.00	05/17/2010	36597159

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/19/2010	05/19/2010

### 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	Rosalind Minor	04/30/2010	04/30/2010	Shellie Howard	05/17/2010	05/17/2010

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Additional Filing Fees	Note To Filer	Rosalind Minor	04/02/2010	04/02/2010

*SERFF Tracking Number:* IADC-126565177 *State:* Arkansas  
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*Project Name/Number:* /

## **Disposition**

Disposition Date: 05/19/2010

Implementation Date:

Status: Approved-Closed

Comment:

As requested, we are withdrawing Form MNL MED BSF 0310 AR effective on this date.

The election form is being approved on this date.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	3rd Party Authorization	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	[Optional] Hearing Aid Rider	Approved-Closed	Yes
Form (revised)	Benefit Selection Form	Withdrawn	Yes
Form	Benefit Selection Form	Withdrawn	Yes
Form	policyholder election form	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 04/30/2010  
Submitted Date 04/30/2010  
Respond By Date 05/14/2010

Dear Shellie Howard,

This will acknowledge receipt of the captioned filing.

### Objection 1

- [Optional] Hearing Aid Rider, MNL HEARDAE AR 0310 (Form)
- Benefit Selection Form, MNL MED BAS 0310 AR (Form)

Comment:

Please refer to my Note to Filer on April 2, 2010.

Before we review your submission, we need an additional filing fee in the amount of \$60.00.

Thank you.

Please feel free to contact me if you have questions.

Sincerely,  
Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 05/17/2010  
Submitted Date 05/17/2010

Dear Rosalind Minor,

### Comments:

Please find response below

### Response 1

Comments: Please accept this as a request for withdrawal of approval request for form MNL MED BSF 0310 AR and the addition of policyholder election form MNL AEAR OPT ELC AR 0510. Also I have sent another \$60 to make up the difference in the fee schedule.

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**Related Objection 1**

Applies To:

- [Optional] Hearing Aid Rider, MNL HEARAIDAE AR 0310 (Form)
- Benefit Selection Form, MNL MED BAS 0310 AR (Form)

Comment:

Please refer to my Note to Filer on April 2, 2010.

Before we review your submission, we need an additional filing fee in the amount of \$60.00.

Thank you.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Benefit Selection Form	MNL MED BAS 0310 AR		Other	Revised	ICCI- 12526663 1/State #36687		
<b>Previous Version</b>							
Benefit Selection Form	MNL MED BAS 0310 AR		Other	Revised	ICCI- 12526663 1/State #36687		MNL MED BSF 0310 AR (Plan Selection Form) 033010.pdf
policyholder election form	MNL AEAR OPT ELC		Other	Initial			MNL AEAR OPT ELC

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*Project Name/Number:* /  
AR 0510

AR 0510  
for filing  
051910.pd  
f

No Rate/Rule Schedule items changed.

Thank you for your continued review of this filing.

Sincerely,  
Shellie Howard

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Project Name/Number: /

**Note To Filer**

**Created By:**

Rosalind Minor on 04/02/2010 03:02 PM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

05/19/2010 12:48 PM

**Subject:**

Additional Filing Fees

**Comments:**

Our filing fees under Rule 57 has been updated. Please review the General Instructions for ArkansasLH.

The fee for this submission should be \$50.00 per form for a total of \$100.00. Please submit an additional \$60.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

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## Form Schedule

### Lead Form Number: MNL HEARAIDAE AR 0310

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/19/2010	MNL HEARAIDA E AR 0310	Certificate t, Insert Page, Endorsement or Rider	[Optional] Hearing Aid Rider	Initial			MNL HEARAIDAE AR 0310 (Optional Hearing Aid Rider)033010.pdf
Withdrawn 05/19/2010	MNL MED BAS AR 0310	Other	Benefit Selection Form	Revised	Replaced Form #: MNL MED BSF 0607-A Previous Filing #: ICCI-125266631/State #36687		
Approved-Closed 05/19/2010	MNL AEAR OPT AR 0510	Other ELC	policyholder election form	Initial			MNL AEAR OPT ELC AR 0510 for filing 051910.pdf

**MADISON NATIONAL LIFE INSURANCE COMPANY, INC.**  
**[P.O. Box 5008, Madison, WI 53705]**

**[OPTIONAL] HEARING AID BENEFIT RIDER  
FOR ARKANSAS RESIDENTS ONLY**

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

If You are covered under the [optional] Hearing Aid Benefit Rider, and if specified as applicable on the Schedule of Benefits, the Certificate is amended as follows:

**A. SECTION 4 – BENEFITS** the following benefit is added:

[22.] Hearing Aids, not subject to Calendar Year Deductible [or Daily Deductible] or Copay, up to \$[1,400] per ear for each [three-year] period. The Hearing Aids must be dispensed by an individual properly licensed by the State of Arkansas.

**B. SECTION 5 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE** the following change is hereby made:

Item [#24] pertaining to routine hearing exams is amended by deleting the reference to “the purchase of hearing aids.”

**C. SECTION 11 – DEFINITIONS** the following definition is added:

**Hearing Aid** means an instrument or device, including repair and replacement parts, that:

- a) Is designed and offered for the purpose of aiding Covered Persons with or compensating for impaired hearing;
- b) Is worn in or on the body; and
- c) Is generally not useful to a person in the absence of a hearing impairment.

**TERMINATION**

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made part of the Policy/Certificate as of [its Effective Date] [[October 1, 2009] or] [Your coverage Effective Date] [whichever is later] [the Effective Date as specified by an attached Endorsement].

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

**MADISON NATIONAL LIFE INSURANCE COMPANY, INC.**



Larry R. Graber  
President



Adam C. Vandervoort  
Secretary

**Madison National Life Insurance Company, Inc.**  
**[1241 John Q Hammons Drive Madison, WI 53717]**

**POLICYHOLDER ELECTION FORM**  
**ARKANSAS RESIDENTS ONLY**

As elected by the Policyholder, and in consideration of any applicable additional premium for each Arkansas resident Certificate holder for each benefit option selected, Covered Charges will include all or any of the following, which will be paid in lieu of any similar benefits described in the Policy. We will not duplicate benefits payable elsewhere under the Policy or any attached Rider.

[1.] Accept \_\_\_\_\_ Reject \_\_\_\_\_ Hearing Aids (Act 1179 of 2009/Bulletin 7A-2009)

As the Policyholder, we request that you indicate above whether you accept or reject this optional benefit:

Policyholder Name: \_\_\_\_\_

Signed for the Policyholder \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> ARCertificate of ComplianceMNL033010.pdf	Approved-Closed	05/19/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> N/A <b>Comments:</b>	Approved-Closed	05/19/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> 3rd Party Authorization <b>Comments:</b> <b>Attachment:</b> MNL Authorization Letter 2010.pdf	Approved-Closed	05/19/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Cover Letter <b>Comments:</b> <b>Attachment:</b> MNL(AR)filing letter 033010.pdf	Approved-Closed	05/19/2010

**Certificate of Compliance with Arkansas Rule and Regulation 19**

Insurer: Madison National Life Insurance Company, Inc.

Form Number(s):

MNL HEARDAE AR 0310

MNL MED BSF AR 0310

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.

Signature of Company Officer:



Adam Vandervoort  
Name

Secretary  
Title

03/30/10  
Date

January 29, 2010

**RE: Madison National Life Insurance Company, Inc.**

NAIC Company Number: 65781  
NAIC Group Number: 0450  
FEIN Number: 39-0990296

**AUTHORIZATION STATEMENT**

Madison National Life Insurance Company, Inc. ("MNL") hereby authorizes IHC Health Solutions (Member of the IHC Group) to represent us in the submission of accident and health insurance forms and rates and to negotiate with the Department for their approval.

Sincerely,



Adam C. Vandervoort  
Secretary



2101 W Peoria Avenue #100  
Phoenix, AZ 85029

March 30, 2010

Honorable Jay Bradford  
Insurance Commissioner  
State of Arkansas  
Arkansas Department of Insurance  
1200 W. Third St.  
Little Rock, AR 72201-1904

**RE: Madison National Life Insurance Company, Inc.**  
**NAIC Company Number: 65781**  
**NAIC Group Number: 0450**  
**FEIN Number: 39-0990296**  
**Master Group Major Medical Insurance Policy – MNL GP 107 and Related Forms**

**New Form:**

MNL HEARDAIDAE AR 0310 [Optional] Hearing Aid Benefit Rider

**Revised Form:**

MNL MED BSF AR 0310 Benefit Selection Form

Dear Commissioner Bradford:

We are submitting for your review and approval, the above referenced out-of-state Group Policy forms on behalf of Madison National Life Insurance Company, Inc.(MNL). This filing is being made in order to comply with Bulletin 7A-2009 & Act 1179 of 2009 regarding the mandatory offering of hearing aids. The Hearing Aid Benefit Rider is a new form and will not replace any approved forms currently on file with the Department. The Benefit Selection Form was revised to reflect the new hearing aid option. This form will replace MNL MED BSF 0607-A approved 08/28/2007 under State Tracking #36687, SERFF #ICCI-125266631. We will list this rider on the Schedule of Benefits as applicable or not applicable, depending on the applicant's selection.

IHC has received authorization to file life, accident, and health forms on MNL's behalf. For your reference, we have enclosed the filing letter of authorization from MNL. Additionally, we have also included a Certification signed by an officer of MNL, in accordance with Rule and Regulation 19.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions. We confirm that the forms meet the minimum required readability standards.

For any questions or if any additional information is needed, please contact me at (602)-861-6070, or by email: [howards@iacusa.com](mailto:howards@iacusa.com). Thank you for your prompt consideration of this filing.

Sincerely,

*Shellie Howard*

Shellie Howard  
Form Development & Compliance Specialist  
PH: 602-861-6070

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## Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/30/2010	Form	Benefit Selection Form	05/17/2010	MNL MED BSF 0310 AR (Plan Selection Form) 033010.pdf (Superseded)



**[PLAN NAME] BENEFIT SELECTION FORM**  
*Underwritten by Madison National Life Insurance Company*

CASE NUMBER \_\_\_\_\_

APPLICANT'S NAME  _____ (LAST) (FIRST) (INITIAL)	SOCIAL SECURITY NUMBER  _____
--	-------------------------------------

**PLAN SELECTION:** Design your plan by selecting your In-Network plan options. Out-of-Network benefits differ from In-Network benefits and are based on your selections below. See the product brochure for details.

[Plan 1]	[Plan 2]	[Plan 3]	[Plan 4]	[Plan 5]	[Plan 6]
<u>Copay</u> <input type="checkbox"/> \$0-\$100					
<u>Deductible</u> <input type="checkbox"/> \$0-\$20,000					
<u>Coinsurance</u> <input type="checkbox"/> 50%-100%					
<u>Maximum out-of-pocket options:</u> <input type="checkbox"/> \$0 - \$50,000					

Preferred Provider Organization (PPO) Network Selected:

**Optional Benefits**

[Outpatient Prescription Drug Coverage]	<input type="checkbox"/> Deductible & Coinsurance Outpatient Rx covered the same as any other illness.	<input type="checkbox"/> Drug Card]
[18-Month Rate Guarantee]	<input type="checkbox"/> Yes <input type="checkbox"/> No (12-Month Rate Guarantee will apply if not elected)	
[Preventive Coverage]	<input type="checkbox"/> Yes <input type="checkbox"/> No]	
[Supplemental Accident]	<input type="checkbox"/> Yes <input type="checkbox"/> No]	
[Maternity Coverage]	<input type="checkbox"/> Yes <input type="checkbox"/> No]	
[Dental Coverage]	<input type="checkbox"/> Yes <input type="checkbox"/> No]	
[Vision Coverage]	<input type="checkbox"/> Yes <input type="checkbox"/> No]	
[Hearing Aid Coverage]	<input type="checkbox"/> Yes <input type="checkbox"/> No] [Not available on HSA-qualified High Deductible Health Plans]	
[24-hour Occupational Coverage]	[Sole proprietors, partners (ownership over 10%), or business owners not covered by Workers' Compensation are eligible. Do you qualify for this benefit? (Verification may be necessary.) Applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No]	
[Mental Health Parity]	<input type="checkbox"/> Yes <input type="checkbox"/> No]	

[Life Insurance <input type="checkbox"/> Yes: <input type="checkbox"/> \$10,000 Minimum <input type="checkbox"/> Other: List amount in \$10,000 increments, up to \$100,000 \$ _____ <input type="checkbox"/> No]	[BENEFICIARY: _____ RELATIONSHIP: _____]
[Dependent Life Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No]	

**Attach this form to your *Application for Insurance***

<b>Case Number</b>	<b>Enter</b>	<b>Date</b>	<b>For Administrative Use Only</b>	<b>Approved By</b>	<b>Date</b>	<b>Eff Date</b>	<b>PCEFDT</b>	<b>Other:</b>
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