

SERFF Tracking Number: LFCR-126605512 State: Arkansas  
Filing Company: Massachusetts Mutual Life Insurance Company State Tracking Number: 45539  
Company Tracking Number: MM500-SAP-1-AR  
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
Product Name: SignatureCare  
Project Name/Number: /

## Filing at a Glance

Company: Massachusetts Mutual Life Insurance Company

Product Name: SignatureCare SERFF Tr Num: LFCR-126605512 State: Arkansas  
TOI: LTC03I Individual Long Term Care SERFF Status: Closed-Approved State Tr Num: 45539  
Sub-TOI: LTC03I.001 Qualified Co Tr Num: MM500-SAP-1-AR State Status: Closed  
Filing Type: Form Reviewer(s): Marie Bennett  
Authors: Smith Darlene, Trudy Weigel Disposition Date: 05/05/2010  
Date Submitted: 04/28/2010 Disposition Status: Approved  
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: Status of Filing in Domicile: Pending  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Group Market Size:  
Overall Rate Impact: Group Market Type:  
Filing Status Changed: 05/05/2010 Explanation for Other Group Market Type:  
State Status Changed: 05/05/2010  
Deemer Date: Created By: Smith Darlene  
Submitted By: Smith Darlene Corresponding Filing Tracking Number: See  
Filing Description: Filing Description/Cover Sheet  
04/28/10

RE: MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY - NAIC # 65935  
MM500-SAP-1-AR (Part 1) – Replacing MM500-SA-1-1-AR (Part 1) Previously Approved for use on 07/21/08 under  
SERFF Filing # LFCR-125715451

For Use with Policy Forms MM-500-P-AR et al Approved on 12/10/07 under  
SERFF Filing #LFCR-125292639

SERFF Tracking Number: LFCR-126605512 State: Arkansas  
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TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
Product Name: SignatureCare  
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The enclosed application is being filed for your review and approval as indicated above.

This application form will be utilized when the multi-life discount is offered to employees of an approved employer group, with a list billing arrangement for the employee. The employee's Covered Partner is also eligible to apply for a separate policy.

This revised application will be used in conjunction with the previously approved Supplemental Application MM500-SA-2-AR (Part 2) (approved 12/10/07 - SERFF Filing #LFCR-125292639) – The Part 2 application will remain as is. (The Supplemental Application is attached for reference)

In order to expedite the application process short form application MM500-SAP-1-AR (Part 1) will be completed by the agent at the worksite. Supplemental Application MM500-SA-2-AR (Part 2) will subsequently be completed via telephone and the Proposed Applicant will be required to sign this application upon delivery of their policy. Both applications will be included with the policy.

Concurrent with this filing, these forms are being filed in the Company's domiciliary state, Massachusetts.

Thank you for your assistance with this filing.

Sincerely,

Julie Storry  
Senior Compliance Analyst  
Phone: (800) 366-5463, extension 2288  
Email: Julie.Storry@LifeCareAssurance.com

## Company and Contact

### Filing Contact Information

Julie Storry, Senior Compliance Analyst julie.storry@lifecareassurance.com  
P.O. Box 4243 818-867-2288 [Phone]  
Woodland Hills, CA 91365-4243 818-867-2508 [FAX]

### Filing Company Information

(This filing was made by a third party - LCA01)

Massachusetts Mutual Life Insurance Company CoCode: 65935 State of Domicile: Massachusetts  
Long Term Care Administrative Office Group Code: 435 Company Type:  
P.O. Box 4243 Group Name: State ID Number:  
Woodland Hills, CA 91365-4243 FEIN Number: 04-1590850  
(818) 867-2450 ext. [Phone]

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$75.00  
Retaliatory? Yes  
Fee Explanation: Domicile state - Massachusetts charges \$75.00 per form filing  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Massachusetts Mutual Life Insurance Company	\$75.00	04/28/2010	36039258

SERFF Tracking Number: LFCR-126605512 State: Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Marie Bennett	05/05/2010	05/05/2010

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## Disposition

Disposition Date: 05/05/2010

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	MM500-SA-2-AR		Yes
Supporting Document	Certificate of Compliance		Yes
Supporting Document	Cover Sheet		Yes
Form	Long Term Care Insurance Application		Yes

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	MM500-SAP-1-AR	Application/Long Term Care Enrollment Insurance Application Form	Revised	Replaced Form #: MM500-SA-1-1-AR Previous Filing #: LFCR-125715451		MM500-SAP-1-AR.pdf

**Massachusetts Mutual Life Insurance Company**

Home Office: Springfield, MA 01111-0001  
 Long Term Care Administrative Office  
 P.O. Box 4243  
 Woodland Hills, CA 91365-4243  
 888.505.8952

**LONG TERM CARE INSURANCE APPLICATION**  
 MM500-SAP-1-AR Part 1 (PLEASE PRINT)

Coverage Type  Individual  (1 Partner Applying)  (Both Partners Applying)

**SECTION 1: PROPOSED APPLICANT PERSONAL INFORMATION**

Proposed Applicant 1		Proposed Applicant 2	
Name (First) (MI) (Last) <i>John Doe</i>	Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Name (First) (MI) (Last) <i>John Doe</i>	Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
Home Address (Street)(City) (State)(ZIP) <i>123 Main St., Anytown, ST 12345-1234</i>		Home Address (Street)(City) (State)(ZIP) <i>123 Main St., Anytown, ST 12345-1234</i>	
Billing Address (if different)		Billing Address (if different)	
Phone Home <i>(555) 555-1212</i> Work <i>(555) 555-1212</i> Best time to call? am or pm / home or work		Phone Home <i>(555) 555-1212</i> Work <i>(555) 555-1212</i> Best time to call? am or pm / home or work	
SS No. <i>123-45-6789</i>	Birth Date <i>1-1-55</i>	SS No. <i>234-56-7891</i>	Birth Date <i>1-1-60</i>
State of Birth <i>Anytown, ST</i>		State of Birth <i>Anytown, ST</i>	
Driver's License No. <i>X1234567</i>	License State <i>ST</i>	Driver's License No. <i>X2345678</i>	License State <i>ST</i>
Email (OPTIONAL): <i>john DOE@email.com</i>		Email (OPTIONAL): <i>janedoe@email.com</i>	
Occupation:		Occupation:	

**SECTION 2: INSURABILITY INFORMATION**

Proposed Applicant 1	Proposed Applicant 2
1. Do you currently need assistance with bathing, dressing, eating, taking medication, transferring from bed to chair or toileting? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. Do you currently need assistance with bathing, dressing, eating, taking medication, transferring from bed to chair or toileting? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. During the past 10 years, have you been medically diagnosed or treated for any of the following: AIDS or positive HIV status..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Alzheimer's Disease, Dementia..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cerebral Palsy..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cystic Fibrosis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hepatitis-Chronic..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Huntington's Chorea..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Insulin Dependent Diabetes..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Kidney Disease requiring dialysis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Liver Cirrhosis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Multiple Sclerosis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Myasthenia Gravis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Organic Brain Syndrome..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Paralysis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Parkinson's /Parkinsonism..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Schizophrenia..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Stroke, TIA..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Systemic Lupus..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	2. During the past 10 years, have you been medically diagnosed or treated for any of the following: AIDS or positive HIV status..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Alzheimer's Disease, Dementia..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cerebral Palsy..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cystic Fibrosis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hepatitis-Chronic..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Huntington's Chorea..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Insulin Dependent Diabetes..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Kidney Disease requiring dialysis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Liver Cirrhosis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Multiple Sclerosis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Myasthenia Gravis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Organic Brain Syndrome..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Paralysis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Parkinson's /Parkinsonism..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Schizophrenia..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Stroke, TIA..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Systemic Lupus..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

**PLEASE NOTE: Before you continue with this application: If you answered YES to any of the questions under INSURABILITY INFORMATION above, we suggest you do not submit the application. If you answered NO to every question, please continue.**



**SECTION 2: INSURABILITY INFORMATION (continued)**

**PRIMARY CARE PHYSICIAN (PCP)**

**Proposed Applicant 1**

3. PCP (current) or MD who has the most complete records of your medical history. If you changed doctors in the past 12 months, please provide the previous doctor's information also. (medical records may be ordered)

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

Address: \_\_\_\_\_

City, State ZIP: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Date/Reason for Last visit: \_\_\_\_\_

Medication(s) prescribed: \_\_\_\_\_

**Proposed Applicant 2**

3. PCP (current) or MD who has the most complete records of your medical history. If you changed doctors in the past 12 months, please provide the previous doctor's information also. (medical records may be ordered)

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

Address: \_\_\_\_\_

City, State ZIP: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Date/Reason for Last visit: \_\_\_\_\_

Medication(s) prescribed: \_\_\_\_\_

**SECTION 3: COVERAGE AND PREMIUM INFORMATION**

**Proposed Applicant 1**

**Proposed Applicant 2**

\* If a PARTNERSHIP POLICY is selected below and You are age **60 or younger**, 5% Compound Inflation Protection or 3% Compound Inflation Protection must be selected and will be issued with Your Policy. If You are age **61-75**, either 5% Compound Inflation Protection, 3% Compound Inflation Protection or 5% Simple Inflation Protection must be selected and will be issued with Your Policy.

**1. Basic Plan Selection**

Partnership Policy       Non-Partnership Policy

Facility Services Only

Comprehensive (Facility Services and Home & Community Based Services (HCBS))

Comprehensive with Indemnity Benefit Rider

Comprehensive with HCBS Monthly Benefit Rider

**2. Daily Benefit Amount (DBA) \$** 100.00

**3. Benefit Period**

Lifetime     10 Years     6 Years     5 Years

4 Years     3 Years     2 Years

**4. Elimination Period**

30 Days     60 Days     90 Days     180 Days

\* Please refer to Partnership Program requirements above.

**5. Inflation Protection Riders (may select only one)**

5% Compound Inflation Protection

3% Compound Inflation Protection

5% Simple Inflation Protection

**6. Return of Premium Riders (may select only one)**

Full Return of Premium on Death (available to age 65)

Return of Premium on Death

**Beneficiary Name** \_\_\_\_\_

**Relationship** \_\_\_\_\_

(Designation of Beneficiary is applicable only in conjunction with one of the Return of Premium Riders)

**7. Elimination Period Riders (may select only one) (not available with Facility Services Only Plan)**

HCBS Waiver of Elimination Period

Enhanced Elimination Period

**8. Other Riders**

Shortened Benefit Period Nonforfeiture

Restoration of Benefits (not available w/ Lifetime Benefit Period)

**9. Covered Partner Riders (if applying as Covered Partners both must select any of the following riders)**

Waiver of Premium for Covered Partner

Paid Up Survivor (available only w/Lifetime Premium Payment Option)

Shared Care (**Covered Partner coverage must be identical**) (not available w/Lifetime Benefit Period)

**1. Basic Plan Selection**

Partnership Policy       Non-Partnership Policy

Facility Services Only

Comprehensive (Facility Services and Home & Community Based Services (HCBS))

Comprehensive with Indemnity Benefit Rider

Comprehensive with HCBS Monthly Benefit Rider

**2. Daily Benefit Amount (DBA) \$** 100.00

**3. Benefit Period**

Lifetime     10 Years     6 Years     5 Years

4 Years     3 Years     2 Years

**4. Elimination Period**

30 Days     60 Days     90 Days     180 Days

\* Please refer to Partnership Program requirements above.

**5. Inflation Protection Riders (may select only one)**

5% Compound Inflation Protection

3% Compound Inflation Protection

5% Simple Inflation Protection

**6. Return of Premium Riders (may select only one)**

Full Return of Premium on Death (available to age 65)

Return of Premium on Death

**Beneficiary Name** \_\_\_\_\_

**Relationship** \_\_\_\_\_

(Designation of Beneficiary is applicable only in conjunction with one of the Return of Premium Riders)

**7. Elimination Period Riders (may select only one) (not available with Facility Services Only Plan)**

HCBS Waiver of Elimination Period

Enhanced Elimination Period

**8. Other Riders**

Shortened Benefit Period Nonforfeiture

Restoration of Benefits (not available w/ Lifetime Benefit Period)

**9. Covered Partner Riders (if applying as Covered Partners both must select any of the following riders)**

Waiver of Premium for Covered Partner

Paid Up Survivor (available only w/Lifetime Premium Payment Option)

Shared Care (**Covered Partner coverage must be identical**) (not available w/Lifetime Benefit Period)



**SECTION 3: COVERAGE AND PREMIUM INFORMATION (continued)**

<p>* Please refer to Partnership Program requirements on page 2.</p> <p><b>10. REJECTION OF INFLATION PROTECTION RIDERS</b> I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without the Inflation Protection Riders and I have chosen to reject these riders. Check Here <input type="checkbox"/></p> <p><b>11. REJECTION OF NONFORFEITURE RIDER</b> I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to reject the rider. Check Here <input type="checkbox"/></p> <p><b>12. Discounts (see Application Instructions)</b>  <input checked="" type="checkbox"/> Covered Partner Discount (2 Proposed Applicants)  <input type="checkbox"/> Partner Discount (1 Proposed Applicant)  <input type="checkbox"/> Loyal Customer Discount Policy No. _____  <input type="checkbox"/> Employer Group Discount                      Group Name and Number _____</p> <p><b>13. Premium Billing (may select only one)</b>  <input checked="" type="checkbox"/> List Bill  <input checked="" type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> PAC</p> <p><b>14. Premium Payment Options (may select only one)</b>  <input checked="" type="checkbox"/> Standard Lifetime  <input type="checkbox"/> Discounted Renewals (only available with Lifetime Premium Payment)  <i>The following two options are not available under age 40</i>  <input type="checkbox"/> 10-Year  <input type="checkbox"/> Paid-Up at Age 65 (available to age 55)</p> <p>Special Request:</p>	<p>* Please refer to Partnership Program requirements on page 2.</p> <p><b>10. REJECTION OF INFLATION PROTECTION RIDERS</b> I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without the Inflation Protection Riders and I have chosen to reject these riders. Check Here <input type="checkbox"/></p> <p><b>11. REJECTION OF NONFORFEITURE RIDER</b> I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to reject the rider. Check Here <input type="checkbox"/></p> <p><b>12. Discounts (see Application Instructions)</b>  <input checked="" type="checkbox"/> Covered Partner Discount (2 Proposed Applicants)  <input type="checkbox"/> Partner Discount (1 Proposed Applicant)  <input type="checkbox"/> Loyal Customer Discount Policy No. _____  <input type="checkbox"/> Employer Group Discount                      Group Name and Number _____</p> <p><b>13. Premium Billing (may select only one)</b>  <input type="checkbox"/> Direct Bill  <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> PAC  <input checked="" type="checkbox"/> List Bill  <input checked="" type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> PAC</p> <p><b>14. Premium Payment Options (may select only one)</b>  <input checked="" type="checkbox"/> Standard Lifetime  <input type="checkbox"/> Discounted Renewals (only available with Lifetime Premium Payment)  <i>The following two options are not available under age 40</i>  <input type="checkbox"/> 10-Year  <input type="checkbox"/> Paid-Up at Age 65 (available to age 55)</p> <p>Special Request:</p>
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**SECTION 4: OTHER COVERAGE/REPLACEMENT INFORMATION**

<p><b>Proposed Applicant 1</b></p> <p>1. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including health care service contract or health maintenance organization contract)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>2. Did you have another long term care insurance policy or certificate in force during the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If that policy lapsed, provide date of lapse _____</p> <p>3. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If you answered YES to any of the questions 1-3 above, provide full details below and complete the required replacement form(s):</p> <p>Question No. _____                      Company/Carrier: _____                      Type of Policy: _____ Issue Date: _____                      Daily Benefit Amount: \$ _____ Paid to Date: _____</p> <p>Question No. _____                      Company/Carrier: _____                      Type of Policy: _____ Issue Date: _____                      Daily Benefit Amount: \$ _____ Paid to Date: _____</p>	<p><b>Proposed Applicant 2</b></p> <p>1. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including health care service contract or health maintenance organization contract)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>2. Did you have another long term care insurance policy or certificate in force during the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If that policy lapsed, provide date of lapse _____</p> <p>3. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If you answered YES to any of the questions 1-3 above, provide full details below and complete the required replacement form(s):</p> <p>Question No. _____                      Company/Carrier: _____                      Type of Policy: _____ Issue Date: _____                      Daily Benefit Amount: \$ _____ Paid to Date: _____</p> <p>Question No. _____                      Company/Carrier: _____                      Type of Policy: _____ Issue Date: _____                      Daily Benefit Amount: \$ _____ Paid to Date: _____</p>
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**SECTION 5: PROTECTION AGAINST UNINTENTIONAL LAPSE**

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

**Proposed Applicant 1 (choose one):**

**Proposed Applicant 2 (choose one):**

<input type="checkbox"/> I elect not to designate any person to receive such notice <input type="checkbox"/> I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium:  Name: _____ Address: _____ Phone: (____) _____ Relationship: _____	<input type="checkbox"/> I elect not to designate any person to receive such notice <input type="checkbox"/> I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium:  Name: _____ Address: _____ Phone: (____) _____ Relationship: _____
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**SECTION 6: COVERED PARTNER OR PARTNER DISCOUNT ELIGIBILITY**

To be eligible for the Partner Discount you must be

- married; or
- named in a valid certificate or license of civil union recognized by the state in which the Policy is issued; or
- living with someone for the past three consecutive years in a committed relationship as partners or as family members and sharing basic living expenses; and
  - are not married to each other or anyone else; and
  - not named in a certificate or license of civil union with each other or anyone else; and
  - if related, belong to the same family generation (e.g. siblings, cousins)

To be eligible for the Covered Partner Discount both applicants must meet the above criteria together.

I meet the criteria listed above. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	I meet the criteria listed above. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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**SECTION 7: PROPOSED APPLICANT STATEMENT**

**NOTICE OF INSURANCE INFORMATION PRACTICES** - To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. The information we obtain about you will be used by Massachusetts Mutual Life Insurance Company to determine eligibility for insurance and/or benefits under an existing policy and for other business purposes in connection with the insurance relationship. The information obtained may not be released to any person or organization except to reinsuring companies, any third party administrators designated by Massachusetts Mutual Life Insurance Company or other persons or organizations performing services in connection with your application, claim or as may be otherwise lawfully required or as you may further authorize. We will furnish a more detailed summary of our information practices upon request.

**AGREEMENT** — The answers given on Part 1 of this application and my subsequent responses on Part 2 of the application are complete and true and were correctly recorded to the best of my knowledge and belief. I understand that the Company will rely on my written answers to the questions in Parts 1 and 2 of this application and that if my answers are not complete and true, my policy may not be valid. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy.

I understand that the policy will become effective and in force on the Policy Effective Date only if the following occur: (1) Parts 1 and 2 of this application are approved by the Company; (2) a policy is issued during the lifetime of the Proposed Applicant; (3) the first premium is paid in full; and (4) there has been no change in the insurability of the Proposed Applicant since the date of completion of Parts 1 and 2 of the application and the date the policy is delivered.

**ACKNOWLEDGMENT** — I acknowledge receipt of an Outline of Coverage, NAIC Shopper's Guide, Potential Rate Increase Disclosure Form, and the Company's notices about the Medical Information Bureau, Inc. (MIB), the Fair Credit Reporting Act, the Company's privacy practices, and the HIPAA Notice of Privacy Practices.

**AUTHORIZATION FOR DISCLOSURE, RECEIPT AND USE OF PERSONAL HEALTH INFORMATION** —

Complete and submit F8186 with this application.

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

This application (including Parts 1 and 2) will be part of the insurance policy for which I am applying. Further, if this application has been completed by two Proposed Applicants I understand that a copy of this application will be included in my Covered Partner's policy. "I", "you", and "your" mean the Proposed Applicant 1 and if applicable, Proposed Applicant 2 applying for coverage under this application.

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

Signed at \_\_\_\_\_ On 3-1-10  
 (City) (State) (Date)

Signature of Proposed Applicant 1: John Doe

Signature of Proposed Applicant 2: Mary Doe

**SECTION 8: AGENT'S STATEMENT**

**8A: Rate Information**

What Rate Class was proposed? Proposed Applicant 1: <input checked="" type="checkbox"/> Ultra Preferred <input type="checkbox"/> Select Preferred <input type="checkbox"/> Preferred Proposed Applicant 2: <input checked="" type="checkbox"/> Ultra Preferred <input type="checkbox"/> Select Preferred <input type="checkbox"/> Preferred	Did you consult the Field Underwriting Guide to determine rate class? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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**8B: Other Coverage and Replacement Information**

Is this part of a multi-Life case (i.e. family members, business partners, etc.)?  Proposed Applicant 1: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Proposed Applicant 2: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Is there a Disability or Life Application being submitted concurrently with this Application?  Proposed Applicant 1: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Proposed Applicant 2: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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**Proposed Applicant 1**

**Proposed Applicant 2**

To the best of your knowledge, is the insurance applied for intended to replace any long term care, medical or health insurance in force with this or any company? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No List any other health insurance policies that you have sold to the Proposed Applicant(s): _____ Which of the policies listed above are still in force, if any? _____ Which of the policies listed above sold in the past 5 years are no longer in force, if any? _____	To the best of your knowledge, is the insurance applied for intended to replace any long term care, medical or health insurance in force with this or any company? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No List any other health insurance policies that you have sold to the Proposed Applicant(s): _____ Which of the policies listed above are still in force, if any? _____ Which of the policies listed above sold in the past 5 years are no longer in force, if any? _____
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**8C: Forms Delivery and Signatures**

Did you provide Proposed Applicant(s) with all required notices? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (if "No", provide details)	Did you ask the Proposed Applicant(s) all the questions face to face and witness their signature(s)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (if "No", provide details)
--	--

I certify that the answers to the questions provided by the Proposed Applicant(s) were fully and accurately recorded in the application, and that the questions in the Agent's Statement have been answered accurately. I have reviewed the current health insurance coverage of the Proposed Applicant(s) and find that the coverage of the type and amount applied for is appropriate for the needs of the Proposed Applicant(s). Further, if this is a replacement, I have reviewed the current health insurance coverage of the Proposed Applicant(s) and find that this replacement is appropriate for the needs of the Proposed Applicant(s).

Licensed Agent's Name (please print) John Q. Porter Ident. Code 1234

Licensed Agent's Signature John Q. Porter Date 3-1-10

Agent's Phone (555) 555-1515

Agent's Fax \_\_\_\_\_ Agency Number \_\_\_\_\_

SERFF Tracking Number: LFCR-126605512 State: Arkansas  
 Filing Company: Massachusetts Mutual Life Insurance Company State Tracking Number: 45539  
 Company Tracking Number: MM500-SAP-1-AR  
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
 Product Name: SignatureCare  
 Project Name/Number: /

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Flesch Certification <b>Bypass Reason:</b> N/A <b>Comments:</b>		
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> Please see Form Schedule <b>Comments:</b>		
<b>Bypassed - Item:</b> Health - Actuarial Justification <b>Bypass Reason:</b> N/A <b>Comments:</b>		
<b>Bypassed - Item:</b> Outline of Coverage <b>Bypass Reason:</b> N/A <b>Comments:</b>		
<b>Satisfied - Item:</b> MM500-SA-2-AR <b>Comments:</b> <b>Attachment:</b> MM500-SA-2-AR.pdf		

SERFF Tracking Number: LFCR-126605512 State: Arkansas  
Filing Company: Massachusetts Mutual Life Insurance Company State Tracking Number: 45539  
Company Tracking Number: MM500-SAP-1-AR  
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
Product Name: SignatureCare  
Project Name/Number: /

**Item Status:**

**Status  
Date:**

**Satisfied - Item:** Certificate of Compliance

**Comments:**

**Attachment:**

MM500SAP1-AR CERT OF COMPLIANCE.pdf

**Item Status:**

**Status  
Date:**

**Satisfied - Item:** Cover Sheet

**Comments:**

**Attachment:**

MM500-SAP-1-AR Cover Sheet.pdf

**Massachusetts Mutual Life Insurance Company**

Home Office: Springfield, MA 01111-0001

Long Term Care Administrative Office

P.O. Box 4243

Woodland Hills, CA 91365-4243

888.505.8952

**SUPPLEMENTAL APPLICATION FOR  
LONG TERM CARE INSURANCE**

MM500-SA-2-AR Part 2 (PLEASE PRINT)

Policy Number:	Policy Number:
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**Section 1: Proposed Applicant(s) Information**

**Proposed Applicant 1**

**Proposed Applicant 2**

Name: _____ First Middle Initial Last	Name: _____ First Middle Initial Last
Social Security Number: _____	Social Security Number: _____
Date of Birth: _____ Month Day Year	Date of Birth: _____ Month Day Year
Insuring Age (as of nearest birthday): _____	Insuring Age (as of nearest birthday): _____

**Section 2: Medical Information**

**Proposed Applicant 1**

**Proposed Applicant 2**

2A. Are you currently receiving Social Security Disability or Medicaid (not Medicare)? <input type="checkbox"/> yes <input type="checkbox"/> no	2A. Are you currently receiving Social Security Disability or Medicaid (not Medicare)? <input type="checkbox"/> yes <input type="checkbox"/> no
2B. Do you currently use or have you used in the past 12 months a walker, crutches, braces, wheelchair, motorized cart, hospital bed, oxygen, or cane? <input type="checkbox"/> yes <input type="checkbox"/> no	2B. Do you currently use or have you used in the past 12 months a walker, crutches, braces, wheelchair, motorized cart, hospital bed, oxygen, or cane? <input type="checkbox"/> yes <input type="checkbox"/> no
2C. Within the past 12 months have you been advised to have any special testing or surgery that has not yet been performed or are you aware of any symptoms or complaints for which you plan to seek medical advice or treatment? <input type="checkbox"/> yes <input type="checkbox"/> no	2C. Within the past 12 months have you been advised to have any special testing or surgery that has not yet been performed or are you aware of any symptoms or complaints for which you plan to seek medical advice or treatment? <input type="checkbox"/> yes <input type="checkbox"/> no
2D. Within the past 12 months, have you received rehabilitative services including physical therapy, occupational therapy, home care or been confined to a nursing home or assisted living facility? <input type="checkbox"/> yes <input type="checkbox"/> no	2D. Within the past 12 months, have you received rehabilitative services including physical therapy, occupational therapy, home care or been confined to a nursing home or assisted living facility? <input type="checkbox"/> yes <input type="checkbox"/> no
2E. Within the past 12 months, have you received disability income or workers' compensation or any other state disability? <input type="checkbox"/> yes <input type="checkbox"/> no	2E. Within the past 12 months, have you received disability income or workers' compensation or any other state disability? <input type="checkbox"/> yes <input type="checkbox"/> no
2F. Within the past 5 years, have you had or been issued a handicap tag? <input type="checkbox"/> yes <input type="checkbox"/> no	2F. Within the past 5 years, have you had or been issued a handicap tag? <input type="checkbox"/> yes <input type="checkbox"/> no
2G. Within the past 5 years, have you been declined for long term care insurance? <input type="checkbox"/> yes <input type="checkbox"/> no	2G. Within the past 5 years, have you been declined for long term care insurance? <input type="checkbox"/> yes <input type="checkbox"/> no



**Section 2: Medical Information (continued)**

**Proposed Applicant 1**

**Proposed Applicant 2**

<p>2H. During the past 10 years, have you received medical advice, consultation, or treatment for the following conditions? If YES, please check appropriate boxes for each Proposed Applicant and provide additional information under the DETAILS section.</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Alcoholism, Drug Dependency</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Blood or Endocrine (Glandular) Disorder</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no High Blood Pressure</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Diabetes</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Brain, Spinal Cord, or Neurological Disease</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Cancer (Internal)</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Heart, Circulatory, Vascular Disorder</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Kidney, Bladder, or Prostate Condition</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Musculoskeletal (bone or joint) or Skin Disorder</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Progressive Eye Condition</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Psychiatric, Mental Disorder, or Depression</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Respiratory or Lung Disorder</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Stomach, Esophagus, Intestine, Liver, or Pancreas Condition</p>	<p>2H. During the past 10 years, have you received medical advice, consultation, or treatment for the following conditions? If YES, please check appropriate boxes for each Proposed Applicant and provide additional information under the DETAILS section.</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Alcoholism, Drug Dependency</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Blood or Endocrine (Glandular) Disorder</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no High Blood Pressure</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Diabetes</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Brain, Spinal Cord, or Neurological Disease</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Cancer (Internal)</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Heart, Circulatory, Vascular Disorder</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Kidney, Bladder, or Prostate Condition</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Musculoskeletal (bone or joint) or Skin Disorder</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Progressive Eye Condition</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Psychiatric, Mental Disorder, or Depression</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Respiratory or Lung Disorder</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Stomach, Esophagus, Intestine, Liver, or Pancreas Condition</p>
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<p>2I. What is your current Weight: _____ Height: _____</p> <p>2J. Any changes in weight of 15 pounds or more within past 12 months?</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>If YES answer above indicate gain or loss and reason:</p> <p>_____</p> <p>2K. Have you smoked cigarettes in past 12 months:</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>If quit, date last smoked? _____</p>	<p>2I. What is your current Weight: _____ Height: _____</p> <p>2J. Any changes in weight of 15 pounds or more within past 12 months?</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>If YES answer above indicate gain or loss and reason:</p> <p>_____</p> <p>2K. Have you smoked cigarettes in past 12 months:</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>If quit, date last smoked? _____</p>
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**Section 3: DETAILS Section**

If you answer YES to any question in Part 2A-H, please give full details of illness, injury, symptoms, duration, treatment and results:

**Proposed Applicant 1**

**Proposed Applicant 2**

Question#
Condition/Diagnosis
Date of Diagnosis or Onset
Treatment Date(s)
Treating Medical Professional/Facility
_____ Name/Address/City/State/Telephone#
_____
_____

Question#
Condition/Diagnosis
Date of Diagnosis or Onset
Treatment Date(s)
Treating Medical Professional/Facility
_____ Name/Address/City/State/Telephone#
_____
_____

Question#
Condition/Diagnosis
Date of Diagnosis or Onset
Treatment Date(s)
Treating Medical Professional/Facility
_____ Name/Address/City/State/Telephone#
_____
_____

Question#
Condition/Diagnosis
Date of Diagnosis or Onset
Treatment Date(s)
Treating Medical Professional/Facility
_____ Name/Address/City/State/Telephone#
_____
_____

**Section 4: Medication Section**

**Medications: List all prescription medications taken at any time over the past 12 months:**

**Proposed Applicant 1**

**Proposed Applicant 2**

Medication/Dosage/Frequency/Reason/MD Prescribed
_____
_____
_____

Medication/Dosage/Frequency/Reason/MD Prescribed
_____
_____
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Medication/Dosage/Frequency/Reason/MD Prescribed
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Medication/Dosage/Frequency/Reason/MD Prescribed
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Medication/Dosage/Frequency/Reason/MD Prescribed
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Medication/Dosage/Frequency/Reason/MD Prescribed
_____
_____
_____

**Section 5: Proposed Applicant Statements**

**AGREEMENT** — The answers given on Part 1 of this application and my subsequent responses on Part 2 of the application are complete and true and were correctly recorded to the best of my knowledge and belief. I understand that the Company will rely on my written answers to the questions in Parts 1 and 2 of this application and that if my answers are not complete and true, my policy may not be valid. I understand that the agent cannot determine eligibility for or alter the terms of the proposed policy.

The following applies individually and separately to each Proposed Applicant: I understand that the insurance applied for will become effective and in force on the Policy Effective Date only if all of the following occur: (1) Parts 1 and 2 of this application are approved by the Company; (2) a policy is issued during the lifetime of the Proposed Applicant; (3) the full first premium is paid; and (4) there has been no change in the insurability of the Proposed Applicant since the date of completion of Parts 1 and 2 of the application and the date the policy is delivered.

**This application (including Parts 1 and 2) will be part of the insurance policy for which I am applying. Further, if this application has been completed by two Proposed Applicants I understand that a copy of this application will be included in my Covered Partner's policy.**

**"I", "you", and "your" mean the Proposed Applicant 1 and if applicable, Proposed Applicant 2 applying for coverage under this application.**

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

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

Signature of Proposed Applicant 1: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Proposed Applicant 2: \_\_\_\_\_ Date \_\_\_\_\_

**CERTIFICATION OF COMPLIANCE**

**Insurer:** \_\_\_\_\_

**The company has reviewed the enclosed policy form(s) and certified that they comply with the provision of Regulation 19 as well as all applicable requirements of the Arkansas Department of Insurance.**

**Signature:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## FORM FILING COVER SHEET

POLICY FORMS FILED FOR USE AS **QUALIFIED TAX STATUS:**

### FORM FILED FOR APPROVAL:

MM500-SAP-1-AR Long Term Care Insurance Application (short form)\

### MM500 PRODUCT ENHANCEMENTS 2010:

MM500R-COMP	Compound Inflation Protection Rider (3% and 5%, options)
MM500R-SIMP	Simple Inflation Protection Rider
MM500R-INDM	Indemnity Benefit Rider
MM500-OOC-AR	Outline of Coverage for long Term Care Policy
MM501-OOC-AR	Outline of Coverage for Facility Services Only Insurance Policy
MM500-AP-AR	Application for Long Term Care Insurance Policy
MM500-CNRT	Conditional Premium Receipt Information
MMD-LTD	Limited Premium Payment Option Disclosure
F8186 0210	Authorization (informational)

**The above referenced forms will be used with the following forms, previously approved for use, as indicated in the filing cover letter.**

MM500-P-AR	Long Term Care Insurance Policy
MM501-P-AR	Facility Services Only Insurance Policy
MM500R-SBN	Shortened Benefit Period Nonforfeiture Rider
MM500R-FROP	Full Return of Premium on Death Rider
MM500R-ROP	Return of Premium on Death Rider
MM500R-EEP	Enhanced Elimination Period Rider
MM500R-MTH	HCBS Monthly Benefit Rider
MM500R-WOE	HCBS Waiver of Elimination Period Rider
MM500R-WOP	Waiver of Premium for Covered Partner Rider
MM500R-SVR	Paid-Up Survivor Benefit Rider
MM500R-SCB	Shared Care Rider
MM500R-ROB	Restoration of Benefits Rider
MM500-AO	Supplemental Application for Policy Ownership
MME-10P	10-Year Premium Payment Endorsement
MME-P65	Paid-Up at Age 65 Premium Payment Endorsement
MME-CNF	Contingent Benefit Upon Lapse
MMD-LCD	Loyal Customer Discount Disclosure
MMD-DRP	Discounted Renewals Premium Payment Option Disclosure
MM500-WRK	Long Term Care Insurance Personal Worksheet

**The above referenced forms will be used with the following forms, as filed under SERFF Filing #LFCR-125715451 on 7/21/08.**

CNFLP1	Contingent Benefit Upon Lapse for Limited Pay Policy
MME-RED1	Lowering Premiums by Reducing Benefits Endorsement
MM-N-LTC	Things You Should Know Before You Buy Long-Term Care Insurance
MM-N-PRI-LP	Potential Rate Increase Disclosure Form
MMD-PRT-AR	Important Notice Regarding Your Policy's LTC Insurance Partnership Status
MMN-PRT-AR	Important Consumer Information Regarding the Arkansas Long Term Care Insurance Partnership Program

**The following forms were approved for use under a separate filing. Copies of the approved forms (and approval dates) were included with the prior filing referenced in the filing cover letter.**

MM-0116-B-2 0907	Replacement Form
MM-0166	Important Notice to Persons on Medicare
None	Sample Long Term Care Insurance Suitability Letter