

SERFF Tracking Number: LFCR-126627806 State: Arkansas
Filing Company: Massachusetts Mutual Life Insurance Company State Tracking Number: 45667
Company Tracking Number: MM500-AO-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-126627806 State: Arkansas
TOI: LTC03I Individual Long Term Care SERFF Status: Closed-Approved State Tr Num: 45667
Sub-TOI: LTC03I.001 Qualified Co Tr Num: MM500-AO-AR State Status: Closed
Filing Type: Form Reviewer(s): Marie Bennett, Harris Shearer
Authors: Smith Darlene, Trudy Weigel Disposition Date: 05/20/2010
Date Submitted: 05/13/2010 Disposition Status: Approved
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: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 05/20/2010 Explanation for Other Group Market Type:
State Status Changed: 05/20/2010
Deemer Date: Created By: Smith Darlene
Submitted By: Smith Darlene Corresponding Filing Tracking Number: See filing description/cover sheet
Filing Description:
May 13, 2010

RE: MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY – NAIC # 65935

Long Term Care filing of Tax-Qualified Policy form MM500-AO-AR

For use with forms previously approved under SERFF Tracking # LFCR-125292639 on 12/10/07 (updated by SERFF Tracking #LFCR-125715451 on 7/21/08 and SERFF Tracking #LFCR-126567407 on 4/14/10)

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The above referenced form is being filed for your review and approval.

A fraud warning has been added to form MM500-AO-AR, Supplemental Application for Policy Ownership, previously approved as MM500-AO under File # LFCR-125292639 on 12/10/07 and will be used if the owner of the policy will be someone other than the insured.

Thank you for your assistance with this filing.

Sincerely,

Julie Storry
Senior Compliance Analyst
(800) 366-5463 ext. 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]

Filing Fees

SERFF Tracking Number: LFCR-126627806 State: Arkansas
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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	05/13/2010	36490548

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Marie Bennett	05/20/2010	05/20/2010

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Disposition

Disposition Date: 05/20/2010

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	Certificate of Compliance		Yes
Supporting Document	Cover Sheet		Yes
Form	Supplemental Application for Policy Ownership		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-AO-AR	Application/ Supplemental Enrollment Form Application for Policy Ownership	Revised	Replaced Form #: MM500-AO Previous Filing #: LFCR-125292639		MM500-AO-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

**SUPPLEMENTAL APPLICATION
FOR POLICY OWNERSHIP
MM500-AO-AR (PLEASE PRINT)**

Proposed Applicant 1 (First Name, Initial, Last Name)	Birthdate	Social Security Number
Proposed Applicant 2 (First Name, Initial, Last Name)	Birthdate	Social Security Number
Proposed Policy Owner and Relationship to Applicant(s)		Social Security or Tax I.D. Number
Residence Address (Street, City, State, Zip)		
Bill to: <input type="radio"/> Owner <input type="radio"/> Insured	Proposed Owner's Billing Address - If Different (Name, Street, City, State, Zip)	
Proposed Policy Owner is: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trustee		

The Contingent Owner will become the policy owner of the Policy in the event of the death of the above named Proposed Policy Owner.

Proposed Contingent Policy Owner and Relationship to Applicant(s)	Social Security or Tax I.D. Number
Residence Address (Street, City, State, Zip)	
Proposed Contingent Owner's Billing Address - If Different (Name, Street, City, State, Zip)	
Proposed Contingent Policy Owner is: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trustee	

Ownership Rights and Benefits

The Proposed Owner, as identified on this form, will have all rights and receive all benefits under the policy.

The Proposed Applicant (the "Insured") may have made certain designations at time of application which the Proposed Owner should review as follows:

1. The owner has the right to name a Beneficiary. The Proposed Owner acknowledges and agrees to the selection of the Beneficiary named in the Application. If the Proposed Owner wishes to change the Beneficiary previously named by the Proposed Applicant, please indicate Beneficiary: _____

NOTE: Designation of Beneficiary is applicable only in conjunction with purchase of the Return of Premium on Death of Insured or the Full Return of Premium on Death of Insured riders.



2. All notices of lapse or termination of this long term care policy for non-payment of premium will be sent to the policy owner and the Insured, if different.

As the Proposed Owner, I understand that I have the right to designate at least one person other than myself and the Insured to receive notice of lapse or termination of this long term care 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. Please check applicable box below:

- I elect NOT to designate any person to receive such notice.
- I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium:

Name: _____

Telephone #: _____

Address: _____

Relationship: _____

3. The owner of the policy has the right to reject the nonforfeiture and inflation protection riders at time of application. The Proposed Owner acknowledges and agrees to the selection to either reject or not the Inflation Protection and Nonforfeiture riders as made in the Application. (Note: If the ownership is changed after the policy has been issued, this paragraph does not apply.)

Signed at _____
City, State

Date

Signature of Proposed Applicant 1

Signature of Proposed Policy Owner

Signature of Proposed Applicant 2

Licensed Agent's Signature

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.

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Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification Bypass Reason: N/A Comments:		
Bypassed - Item: Application Bypass Reason: Attached in Form Schedule Comments:		
Bypassed - Item: Health - Actuarial Justification Bypass Reason: N/A Comments:		
Bypassed - Item: Outline of Coverage Bypass Reason: N/A Comments:		
Satisfied - Item: Certificate of Compliance Comments: Attachment: MM500-AO-AR CERT OF COMPLIANCE.pdf		

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Item Status:

**Status
Date:**

Satisfied - Item: Cover Sheet

Comments:

Attachment:

AR MM500-AO Cover Sheet.pdf

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:

MM500-AO-AR Supplemental Application for Policy Ownership

The above referenced form will be used with the following forms, previously approved for use on 12/10/07 under LFCR-125292639.

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
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

MM500 PRODUCT ENHANCEMENTS 2010, approved 4/14/10 under LFCR-126567407

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, 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