Filing at a Glance

Company: The Order of United Commercial Travelers of America

Product Name: 2010 Medicare Supplement
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010
Sub-TOI: MS08I.001 Plan A 2010
Filing Type: Form/Rate

SERFF Tr Num: WAKE-126588800
SERFF Status: Closed-Approved-Closed
Co Tr Num: AMHUCTMS2010AR

Authors: Toni Hess, Katlyn Gorman, Austin Taylor, Steve Keck, Chris Moser
Date Submitted: 04/21/2010

State: Arkansas
State Tr Num: 45477

State Status: Approved-Closed
Reviewer(s): Stephanie Fowler
Disposition Date: 05/19/2010

Disposition Status: Approved-Closed
Implementation Date: 06/01/2010

Implementation Date Requested: On Approval
State Filing Description:

General Information

Project Name: UCT
Project Number: AMHUCTMS2010AR
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 05/19/2010

Deemer Date:
Submitted By: Toni Hess
Filing Description:
Medicare Supplement Insurance Policies

Plan A – Form Number MSAAA2010 AR
Plan B – Form Number MSAAB2010 AR
Plan F – Form Number MSAAF2010 AR

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 05/19/2010
Created By: Toni Hess
Corresponding Filing Tracking Number:

Plan G – Form Number MSAAG2010 AR
Plan N – Form Number MS AAN2010 AR
Outline of Coverage - Form Number MSI OC 2010 AR
Application - Form Number MS APP 10 AR
Advertising Brochure – Form Number MS B IA 2010
Reinstatement Application – Form Number MS COH 0310
HIPAA Disclosure – Form Number HIPAA 21

Wakely Actuarial Services, Inc. is filing the above-captioned forms, including rates, on behalf of The Order of United Travelers of America. A letter of authorization is included for reference. We are requesting the Department's review and approval of this filing.

The Company is submitting these forms for compliance with the requirements set forth in the NAIC 2010 Medicare Supplement Insurance Model effective 6/1/2010.

Agents licensed in your state will market these plans to consumers.

The filing includes the application, the outline of coverage and the advertising brochure which will be used with these policies. In addition, a Medicare Supplement Certificate of Health which will be used for reinstatement purposes and a HIIPAA disclosure form is also being submitted for use with these forms.

Please also note the Company's Logo is in brackets. This is being done in anticipation of the logo being changed sometime in the future.

Wakely Actuarial Services, Inc. appreciates the Department's time and consideration in the review of this filing for The Order of United Travelers of America.

Company and Contact

Filing Contact Information

Toni Hess, Compliance Consultant toni.hess@hesscc.com
931 Clarmont Avenue 215-485-2582 [Phone]
Bensalem, PA 19020

Filing Company Information

(This filing was made by a third party - WAS01)

The Order of United Commercial Travelers of America
1801 Watermark Drive, Suite 100
P.O. Box 159019
COLUMBUS, OH 43215-8619
(800) 848-0123 ext. [Phone]

CoCode: 56383
Group Code: -99
Group Name:
FEIN Number: 31-4273120

State of Domicile: Ohio
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$450.00
Retaliatory?	No
Fee Explanation:	1 Advertising Brochure - $50 1 Application - $50 5 Med Sup Plans (A,B, F, G, N) - $250 1 Outline of Coverage - $50 1 Rate Page - $50
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Order of United Commercial Travelers of America	$450.00	04/21/2010	35858870

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	05/19/2010	05/19/2010

Disposition

Disposition Date: 05/19/2010
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;

• Both the insured and agent shall be notified by the insurer of its intention to increase the rate for renewal not less than thirty (30) days prior to the effective date of the renewal.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WAKE-126588800*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45477*
Company Tracking Number:	*AMHUCTMS2010AR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*2010 Medicare Supplement*		
Project Name/Number:	*UCT/AMHUCTMS2010AR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Letter of Authorization	Accepted for Informational Purposes	Yes
Form	Medicare Supplement Policy - Plan A	Approved	Yes
Form	Medicare Supplement Policy - Plan B	Approved	Yes
Form	Medicare Supplement Policy - Plan F	Approved	Yes
Form	Medicare Supplement Policy - Plan G	Approved	Yes
Form	Medicare Supplement Policy - Plan N	Approved	Yes
Form	Certificate of Health (Reinstatement)	Approved	Yes
Form	HIPPA Notice	Approved	Yes
Form	Advertising Brochure	Approved	Yes
Rate	Arkansas Medicare Supplement Rate Page	Approved	Yes

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 05/19/2010	MSIAA 2010	Policy/Contract/Fraternal Certificate	Medicare Supplement Policy - Plan A	Initial		41.700	MSIAA2010 AR.pdf
Approved 05/19/2010	MSIAB 2010	Policy/Contract/Fraternal Certificate	Medicare Supplement Policy - Plan B	Initial		41.900	MSIAB2010 AR.pdf
Approved 05/19/2010	MSIAF 2010	Policy/Contract/Fraternal Certificate	Medicare Supplement Policy - Plan F	Initial		45.900	MSIAF2010 AR.pdf
Approved 05/19/2010	MSIAG 2010	Policy/Contract/Fraternal Certificate	Medicare Supplement Policy - Plan G	Initial		45.800	MSIAG2010 AR.pdf
Approved 05/19/2010	MSIAN 2010	Policy/Contract/Fraternal Certificate	Medicare Supplement Policy - Plan N	Initial		45.200	MSIAN2010 AR.pdf
Approved 05/19/2010	MS COH 0310	Other	Certificate of Health (Reinstatement)	Initial		44.500	MS COH 0310.pdf
Approved 05/19/2010	HIPAA 21	Other	HIPPA Notice	Initial		40.000	HIPAA 21.pdf
Approved 05/19/2010	MS B IA 2010	Advertising	Advertising Brochure	Initial		40.000	MS B IA 2010.pdf

UCT® A Fraternal Benefit Society
THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

1801 Watermark Drive, Suite 100
P.O. Box 159019
Columbus, OH 43215-8619

(614) 487-9680
(800) 848-0123 Toll-free
(614) 487-9675 Fax

Web site: www.uct.org

Medicare Supplement Insurance Policy Plan "A"

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.

READ YOUR POLICY CAREFULLY

This is a contract between You and The Order of United Commercial Travelers of America (UCT). We issue this Policy based on the application signed by You and the payment of premiums as stated on the Schedule Page. We will pay the benefits subject to all the terms and conditions of this Policy. This Policy begins on the date of issue listed on the Schedule Page. Payment of each premium as it comes due will continue coverage to the next premium due date.

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

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

1801 Watermark Drive, Suite 100
P.O. Box 159019
Columbus, Ohio 43215-8619

Thirty Day Right To Examine and Return Policy

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

Guaranteed Renewable For Life– Premiums Subject To Change

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as underwriting class, state and zip code of residence. You will be notified at least thirty (30) days in advance before any change in the table of rates.

Signed for the Society at Columbus, Ohio

Chief Executive Officer

THIS POLICY DOES NOT CONTAIN A PRE EXISTING CONDITION LIMITATION
CAUTION
POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT

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Application ..... **Attached**

SCHEDULE PAGE

Insured:

Age At Issue:

Policy Number:

Policy Effective Date:

Premium Mode:

Initial Annual Premium:

Underwriting Class
Gender: [M or F]
Tobacco: [Y or N]
Zip Code: [00000 or NA]

Type of Coverage: **Medicare Supplement Plan [A]**

Definitions

Benefit Period means the period as determined by Medicare which begins on the date when You are confined to a Hospital. It ends when You have not been in either a Hospital or a Skilled Nursing facility for sixty (60) consecutive days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We, Our, Us, Society, UCT means the Order of United Commercial Travelers of America.

You, Your, Yours means the insured named on the Schedule Page.

Benefit Provisions

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

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

Basic (Core) Benefits

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

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

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

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

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

Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Guarantee Regarding Changes In Medicare Benefits

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **Guaranteed Renewable For Life – Premiums Subject To Change** provision on page 1.

Extension of Benefits

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

Medical Assistance Under Medicaid and Suspension Under Group Health Plan

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

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

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

Reinstatement of Your coverage provides for:

1. No waiting period with respect to treatment of preexisting conditions.
2. Coverage equivalent to coverage in effect before the date of suspension unless the Policy provided coverage for outpatient prescription drugs. Reinstatement of the Policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and will be substantially equivalent coverage to the coverage in effect before the date of suspension.
3. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

Exclusions

This Policy does not pay expenses related to any coverage that is limited or excluded by Medicare related to services not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

General Provisions

Entire Contract; Changes: This Policy, including the application, endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by Our Chief Operating Officer and unless such approval shall be endorsed hereon or attached hereto. No agent or officer of any Local, Grand or Supreme Council has authority to change this Policy or to waive any of its provisions.

Time Limit On Certain Defenses: After two (2) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

Grace Period: A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

General Provisions Continued

Reinstatement: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

Notice of Claims: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to the Society at Our Home Office at 1801 Watermark, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

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

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

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

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

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

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

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

General Provisions Continued

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

Conformity With State Statutes: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

Assignment: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to the Society at Our Home Office at 1801 Watermark, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.

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

Cancellation By Insured: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Owner Of Policy: The Insured shall be the Owner of this Policy. The Owner may exercise all options and rights under this Policy.

Maintenance of Solvency: UCT's constitution provides that in the event that its reserves as to all or any class of contracts of insurance issued by it become impaired, the Board of Governors may require that these shall be paid by each owner of such contract of insurance to UCT an amount equal to such owner's equitable proportion of such deficiency as ascertained by the Board of Governors.
If payment of the amount required to be paid is not made by such owner, then either or both of the following, at the election of the owner, shall apply:

1. the amount shall stand as indebtedness against the contract of insurance and shall bear interest at a rate not to exceed ten percent (10%) per annum; or
2. the owner shall accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The owner shall make such election by notifying the Board of Governors of his or her election on a form prescribed by the Board of Governors that shall be provided to each owner. Failure to make such election shall result in a presumption that the owner elects to accept a proportionate reduction in benefits paid pursuant to the contract of insurance

You hereby agree that if You affirmatively elect to have the amount stand as indebtedness against the contract of insurance, then UCT may offset the amount of such indebtedness together with interest thereon against any payment of benefits to You or on Your behalf under the contract of insurance.

Suspension or Expulsion: If the Insured should be expelled or suspended from the membership in the Society for any reason, except for nonpayment of premium or within the contestable period for misrepresentation in the Insured's application for membership, the Insured shall have the privilege of maintaining this Policy in force by continuing payment of the required premium.

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THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

1801 Watermark Drive, Suite 100
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(614) 487-9680
(800) 848-0123 Toll-free
(614) 487-9675 Fax

Web site: www.uct.org

Medicare Supplement Insurance Policy Plan "B"

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.

READ YOUR POLICY CAREFULLY

This is a contract between You and The Order of United Commercial Travelers of America (UCT). We issue this Policy based on the application signed by You and the payment of premiums as stated on the Schedule Page. We will pay the benefits subject to all the terms and conditions of this Policy. This Policy begins on the date of issue listed on the Schedule Page. Payment of each premium as it comes due will continue coverage to the next premium due date.

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

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

1801 Watermark Drive, Suite 100
P.O. Box 159019
Columbus, Ohio 43215-8619

Thirty Day Right To Examine and Return Policy

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

Guaranteed Renewable For Life– Premiums Subject To Change

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as underwriting class, state and zip code of residence. You will be notified at least thirty (30) days in advance before any change in the table of rates.

Signed for the Society at Columbus, Ohio

Chief Executive Officer

THIS POLICY DOES NOT CONTAIN A PRE EXISTING CONDITION LIMITATION
CAUTION
POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT

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- **Owner of Policy** 8
- **Maintenance of Solvency** 8
- **Suspension or Expulsion** 8

Application ..... **Attached**

SCHEDULE PAGE

Insured:

Age At Issue:

Policy Number:

Policy Effective Date:

Premium Mode:

Initial Annual Premium:

Underwriting Class
Gender: [M or F]
Tobacco: [Y or N]
Zip Code: [00000 or NA]

Type of Coverage: **Medicare Supplement Plan [B]**

Definitions

Benefit Period means the period as determined by Medicare which begins on the date when You are confined to a Hospital. It ends when You have not been in either a Hospital or a Skilled Nursing facility for sixty (60) consecutive days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We, Our, Us, Society, UCT means the Order of United Commercial Travelers of America.

You, Your, Yours means the insured named on the Schedule Page.

Benefit Provisions

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

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

Basic (Core) Benefits

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

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

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

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

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

Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Additional Benefits For Plan B

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

Guarantee Regarding Changes In Medicare Benefits

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **Guaranteed Renewable For Life – Premiums Subject To Change** provision on page 1.

Extension of Benefits

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

Medical Assistance Under Medicaid and Suspension Under Group Health Plan

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

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

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

Reinstatement of Your coverage provides for:

1. No waiting period with respect to treatment of preexisting conditions.
2. Coverage equivalent to coverage in effect before the date of suspension unless the Policy provided coverage for outpatient prescription drugs. Reinstatement of the Policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and will be substantially equivalent coverage to the coverage in effect before the date of suspension.
3. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

Exclusions

This Policy does not pay expenses related to any coverage that is limited or excluded by Medicare related to services not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

General Provisions

Entire Contract; Changes: This Policy, including the application, endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by Our Chief Operating Officer and unless such approval shall be endorsed hereon or attached hereto. No agent or officer of any Local, Grand or Supreme Council has authority to change this Policy or to waive any of its provisions.

Time Limit On Certain Defenses: After two (2) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

Grace Period: A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

General Provisions Continued

Reinstatement: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

Notice of Claims: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to the Society at Our Home Office at 1801 Watermark, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

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

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

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

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

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

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

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

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

General Provisions Continued

Conformity With State Statutes: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

Assignment: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to the Society at Our Home Office at 1801 Watermark, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.

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

Cancellation By Insured: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Owner Of Policy: The Insured shall be the Owner of this Policy. The Owner may exercise all options and rights under this Policy.

Maintenance of Solvency: UCT's constitution provides that in the event that its reserves as to all or any class of contracts of insurance issued by it become impaired, the Board of Governors may require that these shall be paid by each owner of such contract of insurance to UCT an amount equal to such owner's equitable proportion of such deficiency as ascertained by the Board of Governors.
If payment of the amount required to be paid is not made by such owner, then either or both of the following, at the election of the owner, shall apply:

1. the amount shall stand as indebtedness against the contract of insurance and shall bear interest at a rate not to exceed ten percent (10%) per annum; or
2. the owner shall accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The owner shall make such election by notifying the Board of Governors of his or her election on a form prescribed by the Board of Governors that shall be provided to each owner. Failure to make such election shall result in a presumption that the owner elects to accept a proportionate reduction in benefits paid pursuant to the contract of insurance

You hereby agree that if You affirmatively elect to have the amount stand as indebtedness against the contract of insurance, then UCT may offset the amount of such indebtedness together with interest thereon against any payment of benefits to You or on Your behalf under the contract of insurance.

Suspension or Expulsion: If the Insured should be expelled or suspended from the membership in the Society for any reason, except for nonpayment of premium or within the contestable period for misrepresentation in the Insured's application for membership, the Insured shall have the privilege of maintaining this Policy in force by continuing payment of the required premium.

UCT® A Fraternal Benefit Society
THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

1801 Watermark Drive, Suite 100
P.O. Box 159019
Columbus, OH 43215-8619

(614) 487-9680
(800) 848-0123 Toll-free
(614) 487-9675 Fax

Web site: www.uct.org

Medicare Supplement Insurance Policy Plan "F"

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.

READ YOUR POLICY CAREFULLY

This is a contract between You and The Order of United Commercial Travelers of America (UCT). We issue this Policy based on the application signed by You and the payment of premiums as stated on the Schedule Page. We will pay the benefits subject to all the terms and conditions of this Policy. This Policy begins on the date of issue listed on the Schedule Page. Payment of each premium as it comes due will continue coverage to the next premium due date.

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

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

1801 Watermark Drive, Suite 100
P.O. Box 159019
Columbus, Ohio 43215-8619

Thirty Day Right To Examine and Return Policy

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

Guaranteed Renewable For Life– Premiums Subject To Change

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as underwriting class, state and zip code of residence. You will be notified at least thirty (30) days in advance before any change in the table of rates.

Signed for the Society at Columbus, Ohio

Chief Executive Officer

THIS POLICY DOES NOT CONTAIN A PRE EXISTING CONDITION LIMITATION
CAUTION
POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT

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Application ..... **Attached**

SCHEDULE PAGE

Insured:

Age At Issue:

Policy Number:

Policy Effective Date:

Premium Mode:

Initial Annual Premium:

Underwriting Class
Gender: [M or F]
Tobacco: [Y or N]
Zip Code: [00000 or NA]

Type of Coverage: **Medicare Supplement Plan [F]**

Definitions

Benefit Period means the period as determined by Medicare which begins on the date when You are confined to a Hospital. It ends when You have not been in either a Hospital or a Skilled Nursing facility for sixty (60) consecutive days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Definitions Continued

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

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

We, Our, Us, Society, UCT means the Order of United Commercial Travelers of America.

You, Your, Yours means the insured named on the Schedule Page.

Benefit Provisions

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

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

Basic (Core) Benefits

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

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

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

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

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

Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Additional Benefits For Plan F

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

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

Additional Benefits For Plan F Continued

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

One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

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

Guarantee Regarding Changes In Medicare Benefits

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **Guaranteed Renewable For Life – Premiums Subject To Change** provision on page 1.

Extension of Benefits

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

Medical Assistance Under Medicaid and Suspension Under Group Health Plan

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

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

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

Reinstatement of Your coverage provides for:

1. No waiting period with respect to treatment of preexisting conditions.
2. Coverage equivalent to coverage in effect before the date of suspension unless the Policy provided coverage for outpatient prescription drugs. Reinstatement of the Policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and will be substantially equivalent coverage to the coverage in effect before the date of suspension.
3. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

Exclusions

This Policy does not pay expenses related to any coverage that is limited or excluded by Medicare related to services not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

General Provisions

Entire Contract; Changes: This Policy, including the application, endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by Our Chief Operating Officer and unless such approval shall be endorsed hereon or attached hereto. No agent or officer of any Local, Grand or Supreme Council has authority to change this Policy or to waive any of its provisions.

Time Limit On Certain Defenses: After two (2) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

Grace Period: A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

Reinstatement: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

Notice of Claims: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to the Society at Our Home Office at 1801 Watermark, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

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

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

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

General Provisions Continued

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

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

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

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

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

Conformity With State Statutes: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

Assignment: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to the Society at Our Home Office at 1801 Watermark, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.

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

Cancellation By Insured: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Owner Of Policy: The Insured shall be the Owner of this Policy. The Owner may exercise all options and rights under this Policy.

Maintenance of Solvency: UCT's constitution provides that in the event that its reserves as to all or any class of contracts of insurance issued by it become impaired, the Board of Governors may require that these shall be paid by each owner of such contract of insurance to UCT an amount equal to such owner's equitable proportion of such deficiency as ascertained by the Board of Governors.
If payment of the amount required to be paid is not made by such owner, then either or both of the following, at the election of the owner, shall apply:

1. the amount shall stand as indebtedness against the contract of insurance and shall bear interest at a rate not to exceed ten percent (10%) per annum; or
2. the owner shall accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The owner shall make such election by notifying the Board of Governors of his or her election on a form prescribed by the Board of Governors that shall be provided to each owner. Failure to make such election shall result in a presumption that the owner elects to accept a proportionate reduction in benefits paid pursuant to the contract of insurance

You hereby agree that if You affirmatively elect to have the amount stand as indebtedness against the contract of insurance, then UCT may offset the amount of such indebtedness together with interest thereon against any payment of benefits to You or on Your behalf under the contract of insurance.

Suspension or Expulsion: If the Insured should be expelled or suspended from the membership in the Society for any reason, except for nonpayment of premium or within the contestable period for misrepresentation in the Insured's application for membership, the Insured shall have the privilege of maintaining this Policy in force by continuing payment of the required premium.

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(614) 487-9680
(800) 848-0123 Toll-free
(614) 487-9675 Fax
Web site: www.uct.org

Medicare Supplement Insurance Policy Plan "G"

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.

READ YOUR POLICY CAREFULLY

This is a contract between You and The Order of United Commercial Travelers of America (UCT). We issue this Policy based on the application signed by You and the payment of premiums as stated on the Schedule Page. We will pay the benefits subject to all the terms and conditions of this Policy. This Policy begins on the date of issue listed on the Schedule Page. Payment of each premium as it comes due will continue coverage to the next premium due date.

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

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

1801 Watermark Drive, Suite 100
P.O. Box 159019
Columbus, Ohio 43215-8619

Thirty Day Right To Examine and Return Policy

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

Guaranteed Renewable For Life– Premiums Subject To Change

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as underwriting class, state and zip code of residence. You will be notified at least thirty (30) days in advance before any change in the table of rates.

Signed for the Society at Columbus, Ohio

Chief Executive Officer

THIS POLICY DOES NOT CONTAIN A PRE EXISTING CONDITION LIMITATION
CAUTION
POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT

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Application ..... **Attached**

SCHEDULE PAGE

Insured:

Age At Issue:

Policy Number:

Policy Effective Date:

Premium Mode:

Initial Annual Premium:

Underwriting Class
Gender: [M or F]
Tobacco: [Y or N]
Zip Code: [00000 or NA]

Type of Coverage: **Medicare Supplement Plan [G]**

Definitions

Benefit Period means the period as determined by Medicare which begins on the date when You are confined to a Hospital. It ends when You have not been in either a Hospital or a Skilled Nursing facility for sixty (60) consecutive days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Definitions Continued

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

We, Our, Us, Society, UCT means the Order of United Commercial Travelers of America.

You, Your, Yours means the insured named on the Schedule Page.

Benefit Provisions

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

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

Basic (Core) Benefits

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

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

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

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

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

Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Additional Benefits For Plan G

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

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

Additional Benefits For Plan G Continued

One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

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

Guarantee Regarding Changes In Medicare Benefits

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **Guaranteed Renewable For Life – Premiums Subject To Change** provision on page 1.

Extension of Benefits

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

Medical Assistance Under Medicaid and Suspension Under Group Health Plan

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

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

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

Reinstatement of Your coverage provides for:

1. No waiting period with respect to treatment of preexisting conditions.
2. Coverage equivalent to coverage in effect before the date of suspension unless the Policy provided coverage for outpatient prescription drugs. Reinstatement of the Policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and will be substantially equivalent coverage to the coverage in effect before the date of suspension.
3. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

Exclusions

This Policy does not pay expenses related to any coverage that is limited or excluded by Medicare related to services not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

General Provisions

Entire Contract; Changes: This Policy, including the application, endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by Our Chief Operating Officer and unless such approval shall be endorsed hereon or attached hereto. No agent or officer of any Local, Grand or Supreme Council has authority to change this Policy or to waive any of its provisions.

Time Limit On Certain Defenses: After two (2) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

Grace Period: A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

Reinstatement: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

Notice of Claims: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to the Society at Our Home Office at 1801 Watermark, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

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

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

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

General Provisions Continued

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

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

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

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

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

Conformity With State Statutes: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

Assignment: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to the Society at Our Home Office at 1801 Watermark, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.

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

Cancellation By Insured: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Owner Of Policy: The Insured shall be the Owner of this Policy. The Owner may exercise all options and rights under this Policy.

Maintenance of Solvency: UCT's constitution provides that in the event that its reserves as to all or any class of contracts of insurance issued by it become impaired, the Board of Governors may require that these shall be paid by each owner of such contract of insurance to UCT an amount equal to such owner's equitable proportion of such deficiency as ascertained by the Board of Governors.
If payment of the amount required to be paid is not made by such owner, then either or both of the following, at the election of the owner, shall apply:

1. the amount shall stand as indebtedness against the contract of insurance and shall bear interest at a rate not to exceed ten percent (10%) per annum; or
2. the owner shall accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The owner shall make such election by notifying the Board of Governors of his or her election on a form prescribed by the Board of Governors that shall be provided to each owner. Failure to make such election shall result in a presumption that the owner elects to accept a proportionate reduction in benefits paid pursuant to the contract of insurance

You hereby agree that if You affirmatively elect to have the amount stand as indebtedness against the contract of insurance, then UCT may offset the amount of such indebtedness together with interest thereon against any payment of benefits to You or on Your behalf under the contract of insurance.

Suspension or Expulsion: If the Insured should be expelled or suspended from the membership in the Society for any reason, except for nonpayment of premium or within the contestable period for misrepresentation in the Insured's application for membership, the Insured shall have the privilege of maintaining this Policy in force by continuing payment of the required premium.

UCT® A Fraternal Benefit Society
THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

1801 Watermark Drive, Suite 100
P.O. Box 159019
Columbus, OH 43215-8619

(614) 487-9680
(800) 848-0123 Toll-free
(614) 487-9675 Fax

Web site: www.uct.org

Medicare Supplement Insurance Policy Plan "N"

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.

READ YOUR POLICY CAREFULLY

This is a contract between You and The Order of United Commercial Travelers of America (UCT). We issue this Policy based on the application signed by You and the payment of premiums as stated on the Schedule Page. We will pay the benefits subject to all the terms and conditions of this Policy. This Policy begins on the date of issue listed on the Schedule Page. Payment of each premium as it comes due will continue coverage to the next premium due date.

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

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

1801 Watermark Drive, Suite 100
P.O. Box 159019
Columbus, Ohio 43215-8619

Thirty Day Right To Examine and Return Policy

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

Guaranteed Renewable For Life– Premiums Subject To Change

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as underwriting class, state and zip code of residence. You will be notified at least thirty (30) days in advance before any change in the table of rates.

Signed for the Society at Columbus, Ohio

Chief Executive Officer

THIS POLICY DOES NOT CONTAIN A PRE EXISTING CONDITION LIMITATION
CAUTION
POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT

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Application ..... **Attached**

SCHEDULE PAGE

Insured:

Age At Issue:

Policy Number:

Policy Effective Date:

Premium Mode:

Initial Annual Premium:

Underwriting Class
Gender: [M or F]
Tobacco: [Y or N]
Zip Code: [00000 or NA]

Type of Coverage:

Medicare Supplement Plan [N]

Definitions

Benefit Period means the period as determined by Medicare which begins on the date when You are confined to a Hospital. It ends when You have not been in either a Hospital or a Skilled Nursing facility for sixty (60) consecutive days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Definitions Continued

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

We, Our, Us, Society, UCT means the Order of United Commercial Travelers of America.

You, Your, Yours means the insured named on the Schedule Page.

Benefit Provisions

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

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

Basic (Core) Benefits

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

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

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

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

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

Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Additional Benefits For Plan N

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

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

Additional Benefits For Plan N Continued

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

Medicare Part B Expenses: Coverage for:

1. The lesser of twenty dollars ($20) or the Medicare Part B coinsurance or co-payments for each covered health care provider office visit (including visits to medical specialists); and

2. The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if admitted to any Hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

Guarantee Regarding Changes In Medicare Benefits

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **Guaranteed Renewable For Life – Premiums Subject To Change** provision on page 1.

Extension of Benefits

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

Medical Assistance Under Medicaid and Suspension Under Group Health Plan

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

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

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

Reinstatement of Your coverage provides for:

1. No waiting period with respect to treatment of preexisting conditions.
2. Coverage equivalent to coverage in effect before the date of suspension unless the Policy provided coverage for outpatient prescription drugs. Reinstatement of the Policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and will be substantially equivalent coverage to the coverage in effect before the date of suspension.
3. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

Exclusions

This Policy does not pay expenses related to any coverage that is limited or excluded by Medicare related to services not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

General Provisions

Entire Contract; Changes: This Policy, including the application, endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by Our Chief Operating Officer and unless such approval shall be endorsed hereon or attached hereto. No agent or officer of any Local, Grand or Supreme Council has authority to change this Policy or to waive any of its provisions.

Time Limit On Certain Defenses: After two (2) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

Grace Period: A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

Reinstatement: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

Notice of Claims: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to the Society at Our Home Office at 1801 Watermark, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

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

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

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

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

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

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

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

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

Conformity With State Statutes: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

Assignment: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to the Society at Our Home Office at 1801 Watermark, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.

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

Cancellation By Insured: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Owner Of Policy: The Insured shall be the Owner of this Policy. The Owner may exercise all options and rights under this Policy.

General Provisions Continued

Maintenance of Solvency: UCT's constitution provides that in the event that its reserves as to all or any class of contracts of insurance issued by it become impaired, the Board of Governors may require that these shall be paid by each owner of such contract of insurance to UCT an amount equal to such owner's equitable proportion of such deficiency as ascertained by the Board of Governors.

If payment of the amount required to be paid is not made by such owner, then either or both of the following, at the election of the owner, shall apply:

1. the amount shall stand as indebtedness against the contract of insurance and shall bear interest at a rate not to exceed ten percent (10%) per annum; or
2. the owner shall accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The owner shall make such election by notifying the Board of Governors of his or her election on a form prescribed by the Board of Governors that shall be provided to each owner. Failure to make such election shall result in a presumption that the owner elects to accept a proportionate reduction in benefits paid pursuant to the contract of insurance

You hereby agree that if You affirmatively elect to have the amount stand as indebtedness against the contract of insurance, then UCT may offset the amount of such indebtedness together with interest thereon against any payment of benefits to You or on Your behalf under the contract of insurance.

Suspension or Expulsion: If the Insured should be expelled or suspended from the membership in the Society for any reason, except for nonpayment of premium or within the contestable period for misrepresentation in the Insured's application for membership, the Insured shall have the privilege of maintaining this Policy in force by continuing payment of the required premium.

[THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA]

The Order of United Commercial Travelers of America
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, OH 43215-8619
(614) 487-9680 • Toll-free: (800) 848-0123 • Fax: (614) 487-9675 • www.uct.org

Policy #: _____
Insured: _____

MEDICARE SUPPLEMENT

Certificate of Health

I hereby apply to The Order of United Commercial Travelers for my policy to be reinstated based on my written answers on my original application.

I understand and agree that this application will become a part of the policy contract; and that any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

To the best of my knowledge and belief, my medical history has not changed since the original application except as stated below:

Date	Medical Treatment	Name and Address of Physician

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health or prescription drug usage to give The Order of United Commercial Travelers of America, or its reinsurers, any such information. I understand that this authorization is voluntary. I understand that I am authorizing The Order of United Commercial of America to receive my health information or prescription drug usage history. The released information received by The Order of United Commercial Travelers of America will remain protected by federal and/or state regulations as long as it is maintained by the health plan. I understand that this authorization will be valid for twelve (12) months from the date signed. A photocopy of this authorization will be treated in the same manner as the original.

_____ _____
Signature Date

_____ _____
Witness Date

THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA
A Fraternal Benefit Society
PEOPLE HELPING PEOPLE

Home Office:
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, OH 43215
(614) 487-9680 • Toll-free: (800) 848-1124 • Fax: (614) 487-9675

Canadian Office:
901 Centre Street North, Room 300, Calgary, AB T2E 2P6
(403) 277-0745 • Toll-free: (800) 267-2371 • Fax: (403) 277-6662

Authorization for Pre-Enrollment Uses and Disclosures of Personal Health Information

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS DESCRIBED BELOW.

1. I authorize United Commercial Travelers (UCT) to use the personal health information I have provided on the application form to determine my eligibility to obtain coverage under the Medicare supplement policy for which I have applied, and to determine the premium rates and terms which apply to the policy.

2. I also authorize all health care providers who have provided treatment or other health care services to me to disclose all information regarding my treatment to UCT.

3. The Underwriting Department of UCT may use my personal health information that is described above.

4. The information that is disclosed by health care providers (as described above) may be used by UCT to determine my eligibility to obtain coverage under the Medicare supplement policy for which I have applied, and to determine the premium rates and terms that apply to the policy.

5. I understand that I may revoke this authorization in writing at any time (except to the extent that action has already been taken by UCT in reliance on this authorization) by sending a written revocation to UCT, 1801 Watermark Drive, Suite 100, Columbus, Ohio, 43215.

6. This authorization will expire 30 months from the date signed (24 months in CO, FL, NE, NC, SD and TX).

7. I understand that the information provided under this authorization is necessary for UCT to determine my eligibility for coverage under the Medicare supplement policy and that UCT will condition approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.

8. I understand that if the person or entity that receives my personal health information is a not a health care provider or health plan covered by the federal privacy regulations (HIPAA), the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations, and will not be used or re-disclosed except as described above, and the information will continue to be protected under the applicable federal privacy regulations.

MEMBER NAME (*please print*) _____

PERSONAL REPRESENTATIVE NAME (*print name, if applicable*) _____

PERSONAL REPRESENTATIVE'S SCOPE OF AUTHORITY to act on member's behalf (*if applicable, e.g. legal guardian, power of attorney, etc.*) _____

SIGNATURE _____ Date _____

SIGNATURE OF UCT REPRESENTATIVE _____ Date _____

Provide a copy of this signed form to the member

Medicare Supplement Insurance

Live the life you've planned... even if you encounter unexpected medical costs!

Medicare pays a portion of your hospital and doctors bills, but Medicare is not designed to cover all of your expenses. A Medicare supplement insurance plan from UCT can help lower your share of the costs. Plus it may pay for additional benefits that Medicare doesn't cover at all.

[2010]

FROM THE ORDER OF
UNITED COMMERCIAL TRAVELERS OF AMERICA

www.uct.org

A Fraternal Benefit Society

Underwritten by The Order of United Commercial Travelers of America
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, OH 43215-8619

[MS B IA 2010]

Protecting You from Bills Medicare Won't Pay

Your Medicare Supplement Benefits

Every plan includes these basic benefits:

Hospitalization: Medicare Part A coinsurance and coverage for 365 additional days after Medicare benefits end

Medical Expenses: Medicare Part B coinsurance (generally 20% of Medicare eligible expenses)

Blood Benefit: Three pints of blood each year

Hospice: Part A coinsurance

Medicare Part A Hospital Coverage

Deductible – Plans B, C, D, F, G and N pay the [$1,100] inpatient hospital deductible for each benefit period.

First 60 Days – After the Medicare Part A deductible, Medicare pays all eligible expenses for services from your first through 60th day of hospital confinement. Services include semiprivate room and board, general nursing, and miscellaneous hospital services and supplies.

Coinsurance – Plans A, B, C, D, F, G and N pay [$275] a day when you are hospitalized from the 61st through the 90th day. And, when you are in the hospital from the 91st day through the 150th day, you receive [$550] a day for each Lifetime Reserve day used.

Extended Hospital Coverage – When you are in the hospital longer than 150 days during a benefit period, and you have exhausted your 60 days of Medicare Lifetime Reserve, Plans A, B, C, D, F, G and N pay the Medicare Part A eligible expenses for hospitalization, paid at the rate Medicare would have paid, subject to a lifetime maximum benefit of an additional 365 days.

Blood Benefit – Medicare has one calendar-year deductible for blood that is the cost of the first three pints needed. Plans A, B, C, D, F, G and N pay this deductible.

Skilled Nursing Facility Care

First 20 Days – Medicare pays all eligible expenses.

Coinsurance – Plans C, D, F, G and N pay up to [$137.50] a day from the 21st through the 100th day during which you receive skilled nursing care. You must enter a Medicare-approved skilled nursing facility within 30 days of being hospitalized for at least three days.

Medicare Part B Physician's Services and Supplies

Deductible – Plans C and F pay the [$155] calendar-year deductible.

Coinsurance – After the Medicare Part B deductible, Plans A, B, C, D, F and G pay 20% of eligible expenses for physician's services, and supplies, physical and speech therapy, and ambulance service. Plan N pays the balance of the Part B coinsurance except up to [$20] copayment for office visits and up to [$50] for emergency room visits.

For hospital outpatient services, the copayment amount will be paid under a prospective payment system. If this system is not used, then 20% of eligible expenses will be paid.

Excess Benefits – Your bill for Medicare Part B services and supplies may exceed the Medicare eligible expense. When that occurs, Plans F and G pay 100% of the difference, up to the charge limitation established by Medicare.

Blood Benefit – Medicare has one calendar-year deductible for blood that is the cost of the first three pints needed. Plans A, B, C, D, F, G and N pay this deductible.

Additional Benefits

Emergency Care Received Outside the U.S. – After you pay a [$250] calendar-year deductible, Plans C, D, F, G and N pay you 80% of eligible expenses incurred during the first 60 days of a trip up to a lifetime maximum of [$50,000]. Benefits are payable for health care you need because of a covered injury or illness.

Choose the Medicare Supplement Plan that's right for you[1]

	Medicare Pays	Medicare Supplement Plans Pay	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan N
Part A: Inpatient Hospital Care									
First 60 days	All but [$1,100]	[$1,100] Part A deductible		✔	✔	✔	✔	✔	✔
Coinsurance 61-90 days	All but [$275] a day	[$275] a day	✔	✔	✔	✔	✔	✔	✔
Coinsurance 91-150 days	All but [$550] a day	[$550] a day	✔	✔	✔	✔	✔	✔	✔
After day 150 up to an additional 365 days in your lifetime	Nothing	100% of eligible expenses	✔	✔	✔	✔	✔	✔	✔
Blood benefit	All but 3 pints	First 3 pints	✔	✔	✔	✔	✔	✔	✔
Skilled Nursing Facility Care									
First 20 days	100%	Nothing							
Coinsurance 21-100 days	All but [$137.50] a day	[$137.50] a day			✔	✔	✔	✔	✔
Part B: Physician's Services and Supplies									
Yearly deductible	Nothing	[$155]			✔		✔		
Coinsurance	Generally 80%	Generally 20%	✔	✔	✔	✔	✔	✔	✔[2]
Blood benefit	All but 3 pints	First 3 pints	✔	✔	✔	✔	✔	✔	✔
Excess benefits	Nothing	100% of eligible expenses					✔	✔	
Additional Benefits Emergency Care Outside the U.S.	Nothing	80% of eligible expenses up to a lifetime maximum of [$50,000] after a [$250] yearly deductible			✔	✔	✔	✔	✔

[1] Some plans may not be available in your state.
[2] Plan N pays the balance of the Part B coinsurance except up to $20 copayment for office visits and up to $50 for emergency room visits.

The Facts About Your Plan

- **Your policy is guaranteed renewable.** Your policy cannot be canceled. It will be renewed as long as the premiums are paid on time and your application is correct.
- **Your benefits will automatically increase** as Medicare deductibles and coinsurance increase. Benefits are not paid for any expenses paid by Medicare.
- **Benefits are paid to you** or to your hospital or doctor.
- **You have 31 days from your renewal date to pay your premium.** Your policy will stay in force during this 31-day grace period.
- **You cannot be singled out for a rate increase, no matter how many times you receive benefits.** Your premium changes when the same premium change is made on all in-force Medicare supplement policies of the same form issued to persons of your classification in the same geographic area of your state. Premiums are based on your age at the time of issue.
- **You are covered immediately.** There is no waiting period for pre-existing conditions. Benefits will be paid from the time your policy is in force.
- **Satisfaction Guaranteed.** If you are not completely happy with your policy, send it back to us or your agent within 30 days after you receive it and we'll refund your premium.
- **Easy Payment Options.** For your convenience, we have several payment options, including our Electronic Funds Transfer (EFT) program, with payments coming out of your bank account automatically. With this payment plan, you'll never have to worry about making late premium payments – even away from home!
- **Medicare Supplement plans will not pay for:**
  - Any expense incurred before your Policy Effective Date
  - Services for which no charge is made
  - Expenses paid by Medicare

Definitions

Medicare Part A eligible expenses for hospital/skilled nursing facility care include expenses for semiprivate room and board, general nursing, and miscellaneous services and supplies.

Medicare Part B eligible expenses for medical services include expenses for physicians' services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service.

Medicare eligible expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

A benefit period begins the first full day you are hospitalized and ends when you have not been in a hospital or skilled nursing facility for 60 days in a row.

Coinsurance is the portion of the eligible expense not paid by Medicare and paid by UCT.

About The Order of United Commercial Travelers of America

[Who we are and what we do

United Commercial Travelers of America, commonly referred to as UCT, is a dynamic not-for-profit organization with active local councils operating in 47 states, the District of Columbia and 10 provinces of Canada. UCT offers our members a unique chance to unite with other individuals who want to get involved and make a difference in their local communities through volunteer services. At the same time we provide members with support through member benefit and discount programs. As a UCT member, you will be assigned to a council in your area in which you may become involved.]

[Community service involvement

Through UCT's local councils, members make a difference in their communities, touching lives through their involvement in a variety of activities that benefit others. Aid to people with intellectual disabilities has been the organization's top-priority civic project since 1959. Local councils and members support Special Olympics as well as schools and workshops for people with intellectual disabilities. UCT also holds an annual international safety poster contest for people with intellectual disabilities. In addition, the UCT Charities Trust Fund Inc. was founded in 1997 as a way to help provide scholarships for students and teachers seeking degrees or certification to teach people with intellectual disabilities through the UCT Scholarship Program.]

[UCT also supports the following programs:

- Cancer education and prevention
- Public safety education
- Youth and drug awareness]

[Prompt, professional service.

Our policyholders enjoy fast and friendly service from our Home Office team, with claims paid promptly to you or your health care provider – whichever you prefer. Should you ever have a question or concern, our customer service specialists are just a toll-free telephone call away. Call them weekdays at (800) 848-0123, from 8 a.m. to 4:30 p.m. Eastern Standard Time.]

THIS IS A BRIEF DESCRIPTION OF YOUR COVERAGE. The outline of coverage must accompany this brochure. For complete information on benefits, exceptions, reductions and limitations, **PLEASE READ YOUR OUTLINE OF COVERAGE AND YOUR POLICY CAREFULLY**. (In WV, the policy may only be applied for 30 days prior to effective date of Medicare eligibility.)

Note: Be detailed and complete when applying for coverage. When you fill out your new policy application, make sure to answer all questions truthfully and completely. UCT may cancel your policy and refuse to pay any claims if you leave out information or falsify important information. Review your application carefully before you sign it to make sure all information has been recorded properly.

This brochure is for the solicitation of insurance and contact will be made by an insurance agent.

Neither The Order of United Commercial Travelers of America, its agents, nor its Medicare supplement policies are connected or endorsed by the U.S. government or the federal Medicare program.

THE ORDER OF
UNITED COMMERCIAL TRAVELERS OF AMERICA

1801 Watermark Drive, Suite 100
P.O. Box 159019
Columbus, Ohio 43215-8619
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Fax: (614) 487-9675
Web: www.uct.org

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved 05/19/2010	Arkansas Medicare Supplement Rate Page	MSIA AR 2010, MSIB AR 2010, MSIF AR 2010, MSIG AR 2010, MSIN AR 2010	New		Arkansas Rate Pages.pdf

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Code 722
Form MSIAA2010 AR
ARKANSAS

2010 STANDARDIZED PLAN A

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	1,794.08	1,794.08	2,243.52	2,243.52
All	Semi-Annual	923.95	923.95	1,155.41	1,155.41
All	Quarterly	470.94	470.94	588.92	588.92
All	EFT Monthly	149.49	149.49	186.93	186.93
All	Direct Monthly	179.40	179.40	224.34	224.34

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Code 722
Form MSIAB2010 AR
ARKANSAS

2010 STANDARDIZED PLAN B

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	2,167.85	2,167.85	2,710.92	2,710.92
All	Semi-Annual	1,116.44	1,116.44	1,396.12	1,396.12
All	Quarterly	569.05	569.05	711.61	711.61
All	EFT Monthly	180.64	180.64	225.88	225.88
All	Direct Monthly	216.77	216.77	271.08	271.08

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Code 722
Form MSIAF2010 AR
ARKANSAS

2010 STANDARDIZED PLAN F

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	2,491.78	2,491.78	3,116.00	3,116.00
All	Semi-Annual	1,283.26	1,283.26	1,604.74	1,604.74
All	Quarterly	654.08	654.08	817.94	817.94
All	EFT Monthly	207.63	207.63	259.63	259.63
All	Direct Monthly	249.16	249.16	311.59	311.59

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Code 722
Form MSIAG2010 AR
ARKANSAS

2010 STANDARDIZED PLAN G

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	2,205.12	2,205.12	2,753.01	2,753.01
All	Semi-Annual	1,135.63	1,135.63	1,417.79	1,417.79
All	Quarterly	578.82	578.82	722.65	722.65
All	EFT Monthly	183.73	183.73	229.40	229.40
All	Direct Monthly	220.50	220.50	275.29	275.29

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Code 722
Form MSIAN2010 AR
ARKANSAS

2010 STANDARDIZED PLAN N

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	1,744.25	1,744.25	2,181.20	2,181.20
All	Semi-Annual	898.28	898.28	1,123.32	1,123.32
All	Quarterly	457.86	457.86	572.56	572.56
All	EFT Monthly	145.34	145.34	181.74	181.74
All	Direct Monthly	174.41	174.41	218.11	218.11

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Codes 720 and 721
Form MSIAA2010 AR
ARKANSAS

2010 STANDARDIZED PLAN A

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	1,614.67	1,614.67	2,019.17	2,019.17
All	Semi-Annual	831.55	831.55	1,039.87	1,039.87
All	Quarterly	423.84	423.84	530.03	530.03
All	EFT Monthly	134.55	134.55	168.24	168.24
All	Direct Monthly	161.45	161.45	201.91	201.91

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Codes 720 and 721
Form MSIAB2010 AR
ARKANSAS

2010 STANDARDIZED PLAN B

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	1,951.06	1,951.06	2,439.83	2,439.83
All	Semi-Annual	1,004.79	1,004.79	1,256.51	1,256.51
All	Quarterly	512.14	512.14	640.45	640.45
All	EFT Monthly	162.58	162.58	203.29	203.29
All	Direct Monthly	195.09	195.09	243.97	243.97

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Codes 720 and 721
Form MSIAF2010 AR
ARKANSAS

2010 STANDARDIZED PLAN F

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	2,242.60	2,242.60	2,804.40	2,804.40
All	Semi-Annual	1,154.93	1,154.93	1,444.27	1,444.27
All	Quarterly	588.67	588.67	736.15	736.15
All	EFT Monthly	186.87	186.87	233.67	233.67
All	Direct Monthly	224.24	224.24	280.43	280.43

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Codes 720 and 721
Form MSIAG2010 AR
ARKANSAS

2010 STANDARDIZED PLAN G

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	1,984.61	1,984.61	2,477.71	2,477.71
All	Semi-Annual	1,022.07	1,022.07	1,276.01	1,276.01
All	Quarterly	520.94	520.94	650.39	650.39
All	EFT Monthly	165.36	165.36	206.46	206.46
All	Direct Monthly	198.45	198.45	247.76	247.76

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Codes 720 and 721
Form MSIAN2010 AR
ARKANSAS

2010 STANDARDIZED PLAN N					
Current Premiums					
		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	1,569.83	1,569.83	1,963.08	1,963.08
All	Semi-Annual	808.45	808.45	1,010.99	1,010.99
All	Quarterly	412.07	412.07	515.30	515.30
All	EFT Monthly	130.81	130.81	163.57	163.57
All	Direct Monthly	156.97	156.97	196.30	196.30

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Codes 716-719 and 723-729
Form MSIAA2010 AR
ARKANSAS

2010 STANDARDIZED PLAN A

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	1,524.97	1,524.97	1,906.99	1,906.99
All	Semi-Annual	785.35	785.35	982.10	982.10
All	Quarterly	400.30	400.30	500.58	500.58
All	EFT Monthly	127.07	127.07	158.90	158.90
All	Direct Monthly	152.49	152.49	190.69	190.69

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Codes 716-719 and 723-729
Form MSIAB2010 AR
ARKANSAS

2010 STANDARDIZED PLAN B

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	1,842.67	1,842.67	2,304.28	2,304.28
All	Semi-Annual	948.97	948.97	1,186.71	1,186.71
All	Quarterly	483.69	483.69	604.87	604.87
All	EFT Monthly	153.55	153.55	192.00	192.00
All	Direct Monthly	184.26	184.26	230.42	230.42

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Codes 716-719 and 723-729
Form MSIAF2010 AR
ARKANSAS

2010 STANDARDIZED PLAN F

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	2,118.01	2,118.01	2,648.60	2,648.60
All	Semi-Annual	1,090.77	1,090.77	1,364.03	1,364.03
All	Quarterly	555.97	555.97	695.25	695.25
All	EFT Monthly	176.49	176.49	220.69	220.69
All	Direct Monthly	211.79	211.79	264.85	264.85

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Codes 716-719 and 723-729
Form MSIAG2010 AR
ARKANSAS

2010 STANDARDIZED PLAN G

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	1,874.35	1,874.35	2,340.06	2,340.06
All	Semi-Annual	965.29	965.29	1,205.12	1,205.12
All	Quarterly	492.00	492.00	614.25	614.25
All	EFT Monthly	156.17	156.17	194.99	194.99
All	Direct Monthly	187.43	187.43	234.00	234.00

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

UNITED COMMERCIAL TRAVELERS OF AMERICA

Gross Annual Premiums for Zip Codes 716-719 and 723-729
Form MSIAN2010 AR
ARKANSAS

2010 STANDARDIZED PLAN N

Current Premiums

		Non-Tobacco		Tobacco	
Age	Mode	Male	Female	Male	Female
All	Annual	1,482.61	1,482.61	1,854.02	1,854.02
All	Semi-Annual	763.54	763.54	954.82	954.82
All	Quarterly	389.18	389.18	486.68	486.68
All	EFT Monthly	123.54	123.54	154.48	154.48
All	Direct Monthly	148.25	148.25	185.39	185.39

Modal Factors

Annual	1.00000
Semi-Annual	0.51500
Quarterly	0.26250
EFT Monthly	0.08333
Direct Monthly	0.10000

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	05/19/2010

Comments:

Attachments:

CONS NOT.pdf
AR - R&R19 Cert H.pdf
AR - R&R49 Cert H.pdf
Readability AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	05/19/2010

Comments:

Attachment:

MS APP 10 AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	05/19/2010

Comments:

Attachment:

MSIOC2010 AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Letter of Authorization	Accepted for Informational Purposes	05/19/2010

Comments:

Attachment:

SERFF Tracking Number:	*WAKE-126588800*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45477*
Company Tracking Number:	*AMHUCTMS2010AR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*2010 Medicare Supplement*		
Project Name/Number:	*UCT/AMHUCTMS2010AR*		

Auth1-15-10.pdf

Consumer Notice
The Order of United Commercial Travelers of America

Policyholder Service Office:	**1801 Watermark Drive, Suite 100** **Columbus, Ohio 43215-8619**
Telephone Number:	**800-848-0123**
Name of Agent:	**[Fred Smith]**
Agent Address:	**[123 First Street, Any Town, Arkansas]**
Agent Telephone Number:	**[555-555-1234]**

If we at The Order of United Commercial Travelers of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-800-852-5494 or 1-501-371-2460

ARKANSAS
Rule and Regulation 19 Certification

Title of Form(s)	Form Number
Medicare Supplement Policy – Plan A	MS IAA 2010
Medicare Supplement Policy – Plan B	MS IAB 2010
Medicare Supplement Policy – Plan F	MS IAF 2010
Medicare Supplement Policy – Plan G	MS IAG 2010
Medicare Supplement Policy – Plan N	MS IAN 2010
Outline of Coverage	MSI OC 2010
Application	MS APP 10
Advertising Brochure	MS B IA 2010
Certificate of Health (Reinstatement)	MS COH 0310
HIPAA Notice	HIPAA-21

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 19, the Unfair Sex Discrimination in the Sale of Insurance.

Signature

Joseph H. Hoffman
Name

Chief Executive Officer
Title

ARKANSAS
Rule and Regulation 49 Certification

Title of Form(s)	Form Number
Medicare Supplement Policy – Plan A	MS IAA 2010
Medicare Supplement Policy – Plan B	MS IAB 2010
Medicare Supplement Policy – Plan F	MS IAF 2010
Medicare Supplement Policy – Plan G	MS IAG 2010
Medicare Supplement Policy – Plan N	MS IAN 2010
Outline of Coverage	MSI OC 2010
Application	MS APP 10
Advertising Brochure	MS B IA 2010
Certificate of Health (Reinstatement)	MS COH 0310
HIPAA Notice	HIPAA-21

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 49, the Life & Health Guaranty Association Notice.

Signature

Joseph H. Hoffman
Name

Chief Executive Officer
Title

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

The Order of United Commercial Travelers of America
1801 Watermark Drive, Suite 100
Columbus, Ohio 43215

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

Type and/or Title of Form(s)	Form Number(s)	Flesch Score
Medicare Supplement Policy – Plan A	MS IAA 2010	41.7
Medicare Supplement Policy – Plan B	MS IAB 2010	41.9
Medicare Supplement Policy – Plan C	MS IAC 2010	41.8
Medicare Supplement Policy – Plan D	MS IAD 2010	45.8
Medicare Supplement Policy – Plan F	MS IAF 2010	45.9
Medicare Supplement Policy – Plan G	MS IAG 2010	45.8
Medicare Supplement Policy – Plan N	MS IAN 2010	45.2
Outline of Coverage	MSI OC 2010	46.9
Application	MS APP 10	42.0
Advertising Brochure	MS B IA 2010	40.0
Certificate of Health (Reinstatement)	MS COH 0310	44.5
HIPAA Notice	HIPAA-21	40.0

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

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

Signature

Joseph H. Hoffman
Name

Chief Executive Officer
Title

The Order of UNITED COMMERCIAL TRAVELERS OF AMERICA
Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
(614) 487-9680, Toll-free: (800) 848-0123, Fax: (800) 984-1039 www.uct.org

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

Requested Effective Date of Policy:

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

WRITE THE PLAN OPTION YOU PREFER:

Plan: _____

If approved, Please: ☐ **Mail Policy to Insured**
☐ **Mail Policy to Agent**

RESIDENCE ADDRESS
Street: _____
City: _____
State: _____ **Zip Code:** _____
E-mail: _____
TELEPHONE: (_____) _____-_____

SOCIAL SECURITY NUMBER:	AGE:	DATE OF BIRTH: *Month / Day / Year*	SEX: ☐ Female ☐ Male	HEIGHT:	WEIGHT:

MEDICARE INFORMATION

1. Did you turn age 65 in the last 6 months?...☐ Ye
2. Did you enroll in Medicare Part B in the last 6 months?.....☐ Ye
   If yes, what is the effective date? _____
3. To the best of your knowledge, what is the date you first enrolled in Medicare Part B?_____

Medicare Claim Number:_____

If Medicare Parts A and B are to be effective at a future date, provide the date both Medicare Parts A and B will be effective:

Part A:_____ Part B: _____

NOTE: Medicare effective date is always the 1st day of the month. Applicant must have both Medicare Parts A & B on the effective date of the policy. If not, coverage cannot be issued.

UNDERWRITING RISK CLASSIFICATION QUESTION

Have you used any form of tobacco in the past two years? ..... ☐ Yes ☐ No
(You do not have to answer this question if you are applying during open enrollment or a guaranteed issue period.)

Are you a member of The Order of United Commercial Travelers of America? ..... ☐ Yes ☐ No
If yes, Council Name: _____
Council City & State: _____

SELECT THE METHOD OF PAYMENT YOU WANT:
☐ Annual ☐ Semi Annual ☐ Quarterly
☐ Monthly EFT ☐ Direct Monthly

MODAL PREMIUM: ..... **$**_____
MODAL FRATERNAL DUES:..... **$**_____
TOTAL MODAL PAYMENT: ..... **$**_____

PART I – HEALTH QUESTIONS

YOU ARE *NOT REQUIRED* TO ANSWER HEALTH QUESTIONS 1-9 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE 6 FOR AN EXPLANATION OF OPEN ENROLLMENT/ GUARANTEED ISSUE PERIOD INFORMATION.

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-8, YOU ARE NOT ELIGIBLE FOR COVERAGE.

1. Are you currently confined in a hospital or skilled nursing facility or extended care facility, or receiving the services of a home health agency? ..... ☐ Yes ☐ No
2. Do you require or receive any assistance with any of your activities of daily living such as bathing, transferring, toileting, eating, dressing, or continence? ..... ☐ Yes ☐ No
3. Are you currently bedridden or do you use the assistance of a wheelchair, walker, or motorized mobility aid?... ☐ Yes ☐ No
4. Within the past two (2) years have you:
   a. Been hospitalized more than 2 times or received home health care services more than 3 times? ..... ☐ Yes ☐ No
   b. Been confined to a nursing facility for more than 30 days? ..... ☐ Yes ☐ No
   c. Been diagnosed with, treated for, or taken medication for Angina; Arrhythmia including chronic or recurrent Atrial Fibrillation; Heart Attack; Heart or Heart Valve Surgery; Implantation of Cardiac Pacemaker; Cardiomyopathy; Myocarditis; Heart Failure; Cardiac or Vascular Angioplasty; Stent Placement; Bypass; unrepaired Aneurysm; or Endarterectomy? ..... ☐ Yes ☐ No
   d. Had a Stroke or Transient Ischemic Attack (TIA)? ..... ☐ Yes ☐ No

5. Do you have now, or in the last two (2) years have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions:
   a. Hepatitis (other than A), Cirrhosis of the Liver or Other Liver Disease? ..... ☐ Yes ☐ No
   b. Major Depression, Bi-Polar Disorder, Schizophrenia, Paranoid or Psychotic Disorder? ..... ☐ Yes ☐ No
   c. Diabetes on Insulin; Diabetic Neuropathy; Retinopathy, Peripheral Vascular Disease; Addison's Disease or Salt Losing Syndrome; Chronic Kidney Disease; Renal Insufficiency; Renal Failure; or any Kidney Disease requiring dialysis? ..... ☐ Yes ☐ No
   d. Crohn's Disease, Ulcerative Colitis, Colostomy (Ostomy), Pancreas Disease, or Disorder of Prostate with elevated PSA level under observation? ..... ☐ Yes ☐ No
   e. Cancer, Leukemia, Hemophilia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma? ..... ☐ Yes ☐ No
   f. Alcohol or Drug Abuse? ..... ☐ Yes ☐ No
   g. Paralysis, Post-Polio Syndrome, Spinal Stenosis, or Osteoporosis with fractures? ..... ☐ Yes ☐ No
   h. Paget's Disease, Rheumatoid or Inflammatory Arthritis, Lupus or other Connective tissue disorder? ..... ☐ Yes ☐ No
6. Do you have now, or at any time have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions:
   a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Dementia, Senility, Alzheimer's Disease, or Organic Brain Disorder? ..... ☐ Yes ☐ No
   b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV) Infection or blood disorder? ..... ☐ Yes ☐ No
   c. Emphysema, Chronic Pulmonary Disease requiring the use of oxygen and/or steroids, or Chronic Obstructive Lung Disease (COLD) excluding Asthma? ..... ☐ Yes ☐ No
   d. Sleep Apnea requiring oxygen and/or positive airway pressure, or sleep apnea diagnosed but not under treatment? ..... ☐ Yes ☐ No
   e. Cardiac condition requiring an internal Defibrillator? ..... ☐ Yes ☐ No
   f. Amputation caused by disease or organ transplant other than corneas? ..... ☐ Yes ☐ No
7. Have you been advised that you will need to be admitted to a hospital, skilled nursing facility or extended care facility or has surgery been advised but not performed, or any surgery anticipated, including cataract surgery?..... ☐ Yes ☐ No
8. Have medical tests, treatment, or therapy been advised but not performed? ..... ☐ Yes ☐ No
9. Are you currently taking any medications? If so, please list the following: ..... ☐ Yes ☐ No

Medication	mg/Dosage	Frequency	Reason for Prescription (Condition)	Length of Time Taken

Phone interviews will be completed on the non-open enrollee/Guarantee Issue applicants.

Daytime Phone No.: (_____)_____-_____Best Time to Call:_____

PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

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

Please mark Yes or No with an "X."

1. To the best of your knowledge,
   a. Do you have another Medicare Supplement policy in force? ..... ☐ Yes ☐ No
   b. If so, with what company and what plan do you have?
   _____
   c. If so, do you intend to replace your current Medicare Supplement policy with this policy? ..... ☐ Yes ☐ No

2. Are you covered for medical assistance through the state Medicaid program? ..... ☐ Yes ☐ No
   NOTE TO APPLICANT: If you are participating in a "Spend-Down" program and have not met your "Share of Cost", please answer NO to this question
   If yes,
   a. Will Medicaid pay your premiums for this Medicare Supplement policy? ..... ☐ Yes ☐ No
   b. Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? ..... ☐ Yes ☐ No

3. a. If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. If you are still covered under this plan, leave "END" blank. ..... START: _____
   END: _____
   b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ..... ☐ Yes ☐ No
   c. Was this your first time in this type of Medicare plan? ..... ☐ Yes ☐ No
   d. Did you drop a Medicare Supplement plan to enroll in the Medicare plan? ..... ☐ Yes ☐ No

4. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ..... ☐ Yes ☐ No
   a. If so, with what company and what kind of policy?
   _____
   _____
   _____
   b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank. ..... START: _____
   END: _____

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

1. You do not need more than one Medicare Supplement Insurance Policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance Policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I hereby apply to The Order of United Commercial Travelers of America for a policy to be issued solely and entirely in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. The Order of United Commercial Travelers of America has the right to deny benefits or rescind my Policy. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy. I agree the policy shall not be effective until it has actually been issued. I have received an outline of coverage for the policy applied for and a *Guide To Health Insurance for People With Medicare*.

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Pre-existing conditions are covered immediately upon effective date under a policy issued by The Order of United Commercial Travelers of America. You are not required to satisfy any waiting period.

If not a current member of The Order of United Commercial Travelers of America, I apply to become a member as indicated by my signature below. I understand UCT is a fraternal benefit society and agree to abide by the Society's Constitution and Bylaws.

Applicant's Signature: _____ Dated: (m/d/y)_____

AGENT(S) CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____

_____

_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____

_____

_____

I (we) certify that:

1. I (we) have accurately recorded the information supplied by the Applicant; and
2. I (we) have given an outline of coverage for the policy applied for and a *Guide To Health Insurance for People With Medicare* to the Applicant.

Agent's Printed Name: _____	**Agent's Printed Name:** _____
Agent No.: _____ **% Amount:** _____	**Agent No.:** _____ **% Amount:** _____
Agent's Signature: _____	**Agent's Signature:** _____
Date: _____	**Date:** _____
E-mail Address: _____	**E-mail Address:** _____

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-9 on Page 1 and 2 of this application if you (a) are within 6 months of turning (about to turn or have already turned 65); (b) are within 6 months of purchasing Part B coverage for the first time; or (c) were previously covered under Medicare (due to a disability, for example) and are within 6 months of turning age 65.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997:

The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

a. Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or
b. Enrolled in a Medicare+Choice or a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
c. Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material certificate/policy provision, or a material misrepresentation was made to the individual; or
d. Enrolled in a Medicare Supplement certificate/policy and coverage discontinues due to insolvency, substantial violation of a material certificate/policy provision, or material misrepresentation; or
e. Enrolled under a UCT Medicare Supplement certificate/policy, terminates and enrolls for the first time in a Medicare+Choice or Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or
f. Upon *first* becoming eligible for benefits under Part B at age 65 or older, enrolled in a Medicare+Choice or a Medicare Advantage or PACE provider and you disenroll within 12 months.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

IF YOU ARE APPLYING DURING AN OPEN ENROLLMENT PERIOD OR A GUARANTEED ISSUE PERIOD, THE AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION TO THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA DOES NOT NEED TO BE COMPLETED OR SIGNED.

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION TO THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health or prescription drug usage to give The Order of United Commercial Travelers of America, or its reinsurers, any such information. I understand that this authorization is voluntary. I understand that I am authorizing The Order of United Commercial Travelers of America to receive my health information or prescription drug usage history. The released information received by The Order of United Commercial Travelers of America will remain protected by federal and/or state regulations as long as it is maintained by the health plan.

Applicant Name: _____

Social Security Number: _____ **Date of Birth:** _____

Reason for Disclosure is to evaluate and underwrite my application to determine eligibility for insurance

I understand that the information requested is necessary for evaluation of my application and underwriting to determine eligibility for the Insurance Policy for which I have applied. I understand that failure to provide the authorization to The Order of United Commercial Travelers of America *will* result in the rejection of the Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying The Order of United Commercial Travelers of America in writing at their Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619. I understand that such revocation will not have any effect on actions The Order of United Commercial Travelers of America took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed. A photocopy of this authorization will be treated in the same manner as the original.

Signature of Applicant: _____ **Date:** _____

AUTHORITY TO HONOR PREMIUM CHECKS

AUTHORIZATION

IN FAVOR OF: **The Order of United Commercial Travelers of America**
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619

Name of Bank Customer: _____ **Type of Account:** ☐ **Checking**

Insured's Name: _____ ☐ **Savings**

Routing Number: _____ **Account Number:** _____

To (Name of Bank): _____

Address of Bank: _____

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America 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 check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America 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 forfeiture of insurance.

Date:	**Signature of Bank Customer:**

AUTHORIZATION

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

To: Bank above: In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

ATTACH VOIDED CHECK HERE – Deposit Slips NOT Accepted

AUTHORIZATION FOR USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION FOR LIFE INSURANCE

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS DESCRIBED BELOW FOR THE LIFE INSURANCE POLICY FOR WHICH I HAVE APPLIED. I UNDERSTAND THAT I MUST COMPLETE THE APPLICATION FOR LIFE INSURANCE AND THIS AUTHORIZATION FORM IN ORDER FOR MY APPLICATION TO BE UNDERWRITTEN.

1. I authorize United Commercial Travelers (UCT) to use the personal health information I have provided on my Medicare supplement application form to determine my eligibility to obtain coverage under the life insurance policy for which I have applied, and to determine the premium rates and terms which apply to the policy.
2. I also authorize all health care providers who have provided treatment or other health care services to me to disclose all information regarding my treatment to UCT.
3. The Underwriting Department of UCT may use my personal health information that is described above.
4. The information that is disclosed by health care providers (as described above) may be used by UCT to determine my eligibility to obtain coverage under the life insurance policy for which I have applied, and to determine the premium rates and terms that apply to the policy.
5. I understand that I may revoke this authorization in writing at any time (except to the extent that action has already been taken by UCT in reliance on this authorization) by sending a written revocation to UCT, 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio, 43215.
6. I understand that the information provided under this authorization is necessary for UCT to determine my eligibility for coverage under the life insurance policy.
7. I understand that if the person or entity that receives my personal health information is a not a health care provider or health plan covered by the federal privacy regulations (HIPAA), the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations, and will not be used or re-disclosed except as described above, and the information will continue to be protected under the applicable federal privacy regulations.
8. I authorize any licensed physician, medical professional, hospital, clinic, pharmacy or other medical or medically related facility, insurance company, MIB, or any other organization that has any records or knowledge of me or my health including advice, care or treatment (including information relating to mental illness and/or use of alcohol or drugs) be provided directly to UCT or its reinsurers. I understand that such information will be used by UCT only to determine my eligibility for insurance. I understand that a photocopy of this authorization shall be as valid as the original and will be valid for 24 months from the date signed. I understand that I have the right to revoke this authorization at any time. I understand that I or my authorized representative may request to receive a copy of this authorization.

I (We) have read and understand the Investigative Consumer Report Notice and the Medical Information Bureau Notice. It is understood that such reports may be required in connection with this application

Member name (*please print*):_____

Personal representative name (*print name, if applicable*):_____

Personal representative's scope of authority to act on member's behalf
(*if applicable, e.g. legal guardian, power of attorney, etc.*): _____

Signature: _____ **Date:** _____

Signature of UCT representative: _____ **Date:** _____

NOTICE TO APPLICANT

This is to inform you that, as a part of our procedure for processing your initial insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. Upon written request, a complete statement as to the nature and scope of this investigation, if one is made, will be provided, together with the names and addresses of each reporting agency. If the application is for family insurance or any other type of insurance on minor child, this notice is also being given to you on behalf of said minor child named in the application.

Information regarding your insurability will be treated as confidential. United Commercial Travelers (UCT) or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information 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 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. UCT or its reinsurer(s) may also release information in its file to other life insurance companies to which you may apply for life or health insurance, or to which a claim for benefits may be submitted. MIB’s website is www.mib.com.

The Order of United Commercial Travelers of America

Outline of Medicare Supplement Coverage
Benefit Plans A, B, C, D, F, G AND N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. The Order of United Commercial Travelers of America offers five of the eleven plans available.
[Plans E, H, I, and J are no longer available for sale. {This sentence shall not appear after June 1, 2011.}]

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 co-payments.
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

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

***Plans F also have 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.**

ANNUAL PREMIUM RATES
FOR USE IN ARKANSAS

All Ages	Plan A		Plan B		Plan F		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Non Tobacco Rates For Zip Codes 722	1,794.08	1,794.08	2,167.85	2,167.85	2,491.78	2,491.78	2,205.12	2,205.12	1,744.25	1,744.25
Tobacco Rates For Zip Codes 722	2,243.52	2,243.52	2,710.92	2,710.92	3,116.00	3,116.00	3,116.00	3,116.00	2,181.20	2,181.20
Non Tobacco Rates For Zip Codes 720-721	1,614.67	1,614.67	1,951.07	1,951.07	2,242.60	2,242.60	1,984.61	1,984.61	1,569.83	1,569.83
Tobacco Rates For Zip Codes 720-721	2,019.17	2,019.17	2,439.83	2,439.83	2,804.40	2,804.40	2,477.71	2,477.71	1,963.08	1,963.08
Non Tobacco Rates For Zip Codes 716-719 and 723-729	1,524.97	1,524.97	1,842.67	1,842.67	2,118.01	2,118.01	1,874.35	1,874.35	1,482.61	1,482.61
Tobacco Rates For Zip Codes 716-719 and 723-729	1,906.99	1,906.99	2,304.28	2,304.28	2,648.60	2,648.60	2,340.06	2,340.06	1,854.02	1,854.02

MODAL FACTORS

Semi-Annual – 0.51500 **Quarterly – 0.26250** **Direct Monthly – 0.10000** **Monthly EFT – 0.08333**

PREMIUM INFORMATION

We, The Order of United Commercial Travelers of America, can only raise your premium if we raise the premium for all policies like yours in this State. Premiums are based on your issue age.

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 The Order of United Commercial Travelers of America.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: The Order of United Commercial Travelers of America, 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619, or to the representative through whom the policy was purchased. 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 The Order of United Commercial Travelers of America 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.

Please refer to your policy for details.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1100]	$0	[$1100] (Part A deductible)
61st thru 90th day	All but $[275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	$0	Up to [$137.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

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

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

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

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	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

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	$0	Up to [$137.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

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

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

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

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	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

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

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

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

PARTS A & B

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

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year 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

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

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

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

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

PARTS A & B

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

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

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

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

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

PARTS A & B

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

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

THE ORDER OF
UNITED COMMERCIAL TRAVELERS OF AMERICA
1801 WATERMARK DRIVE, SUITE 100, P.O. BOX 159019, COLUMBUS, OHIO 43215-8619
(614) 487-9680 • TOLL-FREE: (800) 848-0123 • FAX: (614) 487-9675 • www.uct.org

January 15, 2010

J. Steven Keck, FSA, MAAA
Wakely Actuarial Services, Inc.
34125 US Highway 19 North, Suite 310
Palm Harbor, FL 34684

Dear Mr. Keck:

The firm of Wakely Actuarial Services, Inc. is hereby authorized to submit form filings for approval to the Department of Insurance on behalf of The Order of United Commercial Travelers of America. Changes to the forms, as may be necessary to gain approval, are included in this authorization.

Thank you.

Sincerely,

Joseph Hoffman
Chief Executive Officer