

SERFF Tracking Number: AMLC-126659085 State: Arkansas
Filing Company: Globe Life and Accident Insurance Company State Tracking Number: 45921
Company Tracking Number: ENROLLMENT FORM 10AR
TOI: MS08G Group Medicare Supplement - Standard Sub-TOI: MS08G.001 Plan A 2010
Plans 2010
Product Name: Group Medicare Supplement Enrollment Form 10AR
Project Name/Number: Group Medicare Supplement Enrollment Form 10AR/Group Medicare Supplement Enrollment Form 10AR

Filing at a Glance

Company: Globe Life and Accident Insurance Company

Product Name: Group Medicare Supplement Enrollment Form 10AR SERFF Tr Num: AMLC-126659085 State: Arkansas

TOI: MS08G Group Medicare Supplement - Standard Plans 2010 SERFF Status: Closed-Approved- Closed State Tr Num: 45921

Sub-TOI: MS08G.001 Plan A 2010 Co Tr Num: ENROLLMENT FORM 10AR State Status: Approved-Closed

Filing Type: Form

Author: Phylis Ballard

Date Submitted: 06/10/2010

Reviewer(s): Stephanie Fowler

Disposition Date: 06/11/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Group Medicare Supplement Enrollment Form 10AR

Project Number: Group Medicare Supplement Enrollment Form 10AR

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/11/2010

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed on this day

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Association

Explanation for Other Group Market Type:

State Status Changed: 06/11/2010

Created By: Phylis Ballard

Corresponding Filing Tracking Number:

Enrollment Form 10AR

Deemer Date:

Submitted By: Phylis Ballard

Filing Description:

Enclosed for your review and approval is a copy of the subject Group Medicare Supplement Enrollment form that we wish to use with our certificates which have been previously approved with the requirements set forth by the MMA regarding Medicare Supplement insurance effective June 1, 2010.

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Company and Contact

Filing Contact Information

Phylis Ballard, Compliance Analyst pballard@torchmarkcorp.com
 3700 S. Stonebridge Drive 972-569-3748 [Phone]
 McKinney, TX 75070 972-569-3728 [FAX]

Filing Company Information

Globe Life and Accident Insurance Company	CoCode: 91472	State of Domicile: Nebraska
204 North Robinson Avenue	Group Code: 290	Company Type: Life and Health
Oklahoma City, OK 73102	Group Name: Liberty National	State ID Number:
(405) 270-1400 ext. [Phone]	FEIN Number: 63-0782739	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Globe Life and Accident Insurance Company	\$50.00	06/10/2010	37128408

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	06/11/2010	06/11/2010

SERFF Tracking Number: *AMLC-126659085* *State:* *Arkansas*
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Disposition

Disposition Date: 06/11/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Form Schedule

Lead Form Number: Group Medicare Supplement Enrollment Form 10AR

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved 06/11/2010	10AR	Application/ 10AR Enrollment Form	Initial		57.060	10AR.pdf

1. Please check name and address and complete other information requested.

	Phone Number (____) _____
	E-mail address _____
	Medicare I.D. # (Copy this number from your Medicare I.D. card.) _____
Date of Birth ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Month Day Year	

2. Fill out this section only if you want spouse coverage.

Is spouse enrolling for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Birth ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Medicare I.D. # (Copy this number from spouse's Medicare I.D. card.) _____
Spouse's Name _____	Month Day Year		

3. Check the coverage you want.

APPLICANT: Check one plan <u>only</u> :	Payment Method Selected:	SPOUSE: Check one plan <u>only</u> :	Payment Method Selected:
<input type="checkbox"/> Plan A PLAN CODE [J80]	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<input type="checkbox"/> Plan A PLAN CODE [J80]	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly
<input type="checkbox"/> Plan B [J81]	<input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	<input type="checkbox"/> Plan B [J81]	<input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual
<input type="checkbox"/> Plan C [J82]	Premium Submitted For Applicant:	<input type="checkbox"/> Plan C [J82]	Premium Submitted For Spouse:
<input type="checkbox"/> Plan F [J83]	\$ _____	<input type="checkbox"/> Plan F [J83]	\$ _____

4. Please answer the questions. If spouse is applying for coverage, make sure you answer for both you and your spouse.

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

TO THE BEST OF YOUR KNOWLEDGE:

	<u>APPLICANT</u>	<u>SPOUSE</u>
1. (a) Did you turn 65 in the last six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Did you enroll in Medicare Part B in the last six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) If "YES", what is the effective date? _____		
(d) What is your Medicare Claim Number? _____		
2. Are you covered for medical assistance through the State Medicaid program? NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer "NO" to this question. If you answer "YES",	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Will Medicaid pay your premiums for this Medicare Supplement policy or certificate?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end date below. If you are still covered under this plan, leave "END Date" blank. Applicant START Date _____ END Date _____ Spouse START Date _____ END Date _____		
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy or certificate?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Was this your first time in this type of Medicare plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Did you drop a Medicare Supplement policy or certificate to enroll in the Medicare plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. (a) Do you have another Medicare Supplement policy or certificate in force?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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 coverage with this policy or certificate?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) If so, with what company and what kind of policy or certificate? _____		
(b) What are your dates of coverage under the other policy or certificate? (If you are still covered under the other policy or certificate, leave "END Date" blank.) Applicant START Date _____ END Date _____ Spouse START Date _____ END Date _____		

4. Continued Please answer the questions. If spouse is applying for coverage, make sure you answer for both you and your spouse.

TO THE BEST OF YOUR KNOWLEDGE:	<u>APPLICANT</u>	<u>SPOUSE</u>
6. Are you within 6 months of your enrollment in Medicare Part B or otherwise qualified for open enrollment? (Questions 7-12 not required if the answer to question 6 is "YES".)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
IF THE ANSWER TO ANY OF QUESTIONS 7-12 IS "YES", THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE.		
7. Are you currently hospitalized, confined to a nursing facility or receiving Medicare approved home health care; or have you been hospitalized or received Medicare approved home health care 2 or more times in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are you bedridden, or confined to a wheelchair, or have you been diagnosed with Gaucher's Disease or any other type of lysosomal storage disorder, or during the past 2 years, have you had any type of amputation caused by disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Within the past year, have you been medically advised to have surgery for cataracts, or for joint replacement, or for a heart condition, but not had such surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Within the past year, have you been diagnosed or treated for internal cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Within the past 2 years, have you been diagnosed or treated for heart valve surgery, Alzheimer's disease, or cirrhosis of the liver?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Within the past 2 years, have you had or been advised to have kidney dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Please read and sign your name below.

(1) You do not need more than one Medicare Supplement policy or certificate. (2) If you purchase this policy or certificate, 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 policy or certificate. (4) If, after purchasing this policy or certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy or certificate 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 certificate (or, if that is no longer available, a substantially equivalent policy or certificate) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy or certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy or certificate was suspended, the reinstated policy or certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension. (5) If you are eligible for, and have enrolled in a Medicare Supplement policy or certificate 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 or certificate 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 or certificate under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy or certificate (or, if that is no longer available, a substantially equivalent policy or certificate) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy or certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy or certificate was suspended, the reinstated policy or certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension. (6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I hereby apply to Globe Life And Accident Insurance Company for a policy or certificate to be issued in reliance on my written answers to the above questions. The answers are, to the best of my knowledge and belief, true. I agree the policy or certificate shall not be effective unless it has actually been issued.

I understand that loss due to injury or sickness for which medical advice was received or treatment was recommended or given by a physician within 3 months prior to the policy or certificate effective date is not covered unless the loss is incurred more than 60 days after the policy or certificate effective date, subject to the Time Limit on Certain Defenses provision and legal proceedings.

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

Signed at _____ This _____ day of _____
(City) (State) (Year)

Signed _____ Signed _____
(Applicant's) (Spouse)

6. Complete this Section ONLY if you answered "YES" to any of Questions 7 - 12 in Section 4 above.

I. INVOLUNTARY TERMINATION OF COVERAGE:

If your previous coverage was terminated involuntarily, please provide a copy of the notice of termination of coverage and attach it to this form.

What type of coverage was terminated? _____

Date of termination? ____ / ____ / ____ Reason for termination? _____

II. VOLUNTARY TERMINATION OF COVERAGE:

If you voluntarily terminated your present coverage, please attach evidence of previous coverage to this form.

What type of coverage was terminated? _____

Date of termination? ____ / ____ / ____ Reason for termination? _____

If you voluntarily terminated coverage under a Medicare Advantage plan or Medicare Select policy or certificate, please answer the following questions:*

	Applicant	Spouse
1. Was this the first time you were ever enrolled in a Medicare Advantage plan or purchased a Medicare Select Policy or certificate? If so, did you have the Medicare Advantage plan or Medicare Select policy or certificate for less than 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Did you have a Medicare Supplement policy or certificate before applying for the Medicare Advantage plan or Medicare Select policy or certificate? If "YES", with which Company and which Medicare Supplement plan? _____ Is that Company still offering that Medicare Supplement plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

* Medicare Advantage plan means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1) and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and (3) Medicare Advantage private fee-for-service plans.

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Accepted for Informational Purposes	06/11/2010

Comments:

Attachment:

Readability Cert.pdf

	Item Status:	Status Date:
Satisfied - Item: Application		

Comments:

This is listed under Form Schedule.

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification		

Comments:

na

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage		

Comments:

na

CERTIFICATION

This is to certify that the attached Policy Form see below

has achieved Flesch Reading Ease Score of * and complies with the requirements of Arkansas Stat. Ann. SS66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.



Michael J. Gaisbauer, Vice President

SUPPLEMENTAL FORMS

SCORE

Enrollment Form 10AR

57.06