Filing at a Glance

Company: Old Surety Life Insurance Company

Product Name: 2010 Standardized Medicare Supp Plan A

SERFF Tr Num: OSLI-126565532

State: Arkansas

TOI: MS08I Individual Medicare Supplement - Standard Plans 2010

SERFF Status: Reopened-Approved-Closed

State Tr Num: 45937

Sub-TOI: MS08I.001 Plan A 2010

Co Tr Num:

State Status: Waiting Industry Response

Filing Type: Form/Rate

Reviewer(s): Stephanie Fowler

Author: Dwight Herron

Disposition Date: 06/21/2010

Date Submitted: 06/10/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/21/2010

Deemer Date:

Submitted By: Dwight Herron

Filing Description:

2010 Standardized Medicare Supp Plan A

Status of Filing in Domicile: Pending

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: 06/21/2010

Created By: Dwight Herron

Corresponding Filing Tracking Number:

Company and Contact

Filing Contact Information

Dwight Herron, Secretary & Vice President dherron@oldsurety.com

P O Box 54407 800-272-5466 [Phone]
Oklahoma City, OK 73154 405-524-4011 [FAX]

Filing Company Information

Old Surety Life Insurance Company	CoCode: 67326	State of Domicile: Oklahoma
P O Box 54407	Group Code:	Company Type: Life & Health
Oklahoma City, OK 73154	Group Name:	State ID Number:
(800) 272-5466 ext. [Phone]	FEIN Number: 73-0385800	

Filing Fees

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	No
Fee Explanation:	$ 50.00 - Form 600-A-AR
	$ 50.00 - Form BRC AR
	$ 50.00 - Form MSAP AR
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Old Surety Life Insurance Company	$0.00	06/10/2010	

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
0015160	$50.00	06/09/2010
0016017	$50.00	06/10/2010
0016016	$50.00	06/10/2010

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	06/21/2010	06/21/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Stephanie Fowler	06/14/2010	06/14/2010	Dwight Herron	06/15/2010	06/15/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Rates	Note To Filer	Stephanie Fowler	06/21/2010	06/21/2010

Disposition

Disposition Date: 06/21/2010
Implementation Date: 06/21/2010
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:	*OSLI-126565532*	*State:*	*Arkansas*
Filing Company:	*Old Surety Life Insurance Company*	*State Tracking Number:*	*45937*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*2010 Standardized Medicare Supp Plan A*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document *(revised)*	Application	Approved	Yes
Supporting Document	Application	Disapproved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Health - Actuarial Justification	Disapproved	No
Supporting Document	Outline of Coverage	Approved	Yes
Form	2010 Standardized Medicare Supp Plan A	Approved	Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/14/2010
Submitted Date	06/14/2010
Respond By Date	07/14/2010

Dear Dwight Herron,

This will acknowledge receipt of the captioned filing.

Objection 1

- Flesch Certification (Supporting Document)
- Application (Supporting Document)
- Health - Actuarial Justification (Supporting Document)
- Outline of Coverage (Supporting Document)
- 2010 Standardized Medicare Supp Plan A, Form 600-A-AR (Form)

Comment: AR Rule and Regulation 27 s6(C) states "No Medicare supplement policy or certificate may include a policy fee or any other similar charge. Applicants cannot be required to pay any fee other than the approved premium".

Please revise this filing to comply.

Also, please submit a copy of the proposed base monthly rates by dollar amount.

Please feel free to contact me if you have questions.
Sincerely,
Stephanie Fowler

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/15/2010
Submitted Date	06/15/2010

Dear Stephanie Fowler,

Comments:
Per your request I have attached a copy of the full set of rates under the Supporting Documentation tab following the actuarial memorandum.

Response 1

Comments: We have removed the reference to a policy fee from the application (page 6) and attached the corrected Form MSAP 600 AR under the Supportinging Documentation tab.

Related Objection 1

Applies To:

- Flesch Certification (Supporting Document)
- Application (Supporting Document)
- Health - Actuarial Justification (Supporting Document)
- Outline of Coverage (Supporting Document)
- 2010 Standardized Medicare Supp Plan A, Form 600-A-AR (Form)

Comment:
AR Rule and Regulation 27 s6(C) states "No Medicare supplement policy or certificate may include a policy fee or any other similar charge. Applicants cannot be required to pay any fee other than the approved premium".

Please revise this filing to comply.

Changed Items:

Supporting Document Schedule Item Changes
Satisfied -Name: Application
Comment: We have removed the reference to a policy fee in the application (page 6). We apologize for the oversight.
Satisfied -Name: Health - Actuarial Justification
Comment: We have attached a copy of the rates as well.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If you have any questions or further requests please feel free to contact me at 1-800-272-5466 or dherron@oldsurety.com.

Sincerely,
Dwight Herron

Note To Filer

Created By:

Stephanie Fowler on 06/21/2010 10:48 AM

Last Edited By:

Stephanie Fowler

Submitted On:

06/21/2010 10:48 AM

Subject:

Rates

Comments:

Hey Dwight, I still need those rates.

Thank you,
Stephanie

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 06/21/2010	Form 600-A-AR	Policy/Contract/Fraternal Certificate	2010 Standardized Medicare Supp Plan A	Initial			Medicare Supp 2010 Plan A Policy - AR.pdf

Medicare Supplement Policy

Plan A

*** ***

WARNING : Any person who knowingly, and with intent to injure, defraud or deceive, any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

*** * * * * * * * * * * * * * * * * * * \

THIS POLICY PROVIDES BENEFITS FOR LOSS DUE TO HOSPITAL CONFINEMENT AND FOR OTHER SPECIFIED EXPENSE RESULTING FROM ACCIDENTAL BODILY INJURY OR SICKNESS FOR INDIVIDUALS TO THE EXTENT HEREIN LIMITED AND PROVIDED.

MEDICARE SUPPLEMENT POLICY – PLAN A

OLD SURETY LIFE
INSURANCE COMPANY
P.O. BOX 54407 - OKLAHOMA CITY, OK 73154-1407
405-523-2112
Toll Free # 1-800-272-5466

"Serving you -since '32"

HEREIN CALLED COMPANY

THE INSURING CLAUSE

HEREBY INSURES the Applicant, named in the application and/or Schedule I attached hereto, hereinafter called the Insured Person, against loss, subject to all provisions and limitations and exclusions herein contained, and will pay the benefits provided herein for hospital confinement and other specified expense incurred beginning while this policy is in force:

(a) resulting from accidental bodily injury, hereinafter referred to as such accident; and
(b) resulting from sickness, hereinafter referred to as such sickness.

NOTICE TO BUYER: This policy may not cover all of your medical expenses.

RIGHT TO EXAMINE POLICY

Please read your policy carefully, examine its provisions, so that you will know what benefits you will be entitled to when sickness and accidents occur. If you are not satisfied with the policy for any reason, you are permitted to return the policy within thirty (30) days to the home office after same has been delivered to you and/or to the address furnished by you in the application, and any premium paid by you will be refunded in full. In the event that you exercise said prerogative, it is deemed that the policy is null and void from the beginning as if no policy had been issued.

RIGHT TO CHANGE RATES

The company reserves the right to change, at any time and from time to time, the table of rates applicable to premiums thereafter becoming due under all policies of this same class in the Insured Person's state of residence. Such right includes the right of automatic change of premiums for this policy on a proportionate basis, on the renewal date following the effective date of any changes in the deductibles and/or coinsurance amounts the Insured Person is required to pay under Medicare whereby benefits of this policy are automatically changed.

NO CHANGE OF RATES OR PREMIUMS FOR THIS POLICY WILL BE MADE ON ACCOUNT OF ANY PHYSICAL IMPAIRMENT OF ANY INSURED PERSON OR ON ACCOUNT OF ANY CLAIMS INCURRED THEREUNDER. PREMIUM RATES CANNOT BE CHANGED UNLESS THE PREMIUM RATES OF ALL POLICIES OF THIS SAME CLASS WITHIN THE INSURED PERSON'S STATE OF RESIDENCE ARE SO CHANGED.

RENEWAL PROVISION

THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE. THE COMPANY CANNOT CANCEL OR NONRENEW THIS POLICY EXCEPT FOR NON-PAYMENT OF PREMIUM OR MATERIAL MISREPRESENTATION. THE COMPANY RESERVES THE RIGHT TO CHANGE PREMIUM RATES ON A CLASS BASIS BY STATE OF RESIDENCE

DEFINITIONS

Whenever used in this policy:

ACCIDENT or ACCIDENTAL INJURY means accidental bodily injury sustained by the Insured Person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while this coverage is in force.

BENEFIT PERIOD means a Medicare benefit period which begins with the first day an Insured Person is confined in a hospital as a resident bed patient as a result of such injury or such sickness. The benefit period ends at the close of sixty (60) consecutive days on each of which the Insured Person was not confined in a Hospital or Skilled Nursing Facility.

HOSPITAL means an institution licensed and operated pursuant to law, primarily and continuously engaged in providing medical, diagnostic and major surgical facilities for compensation from its patient. Services must be provided under the supervision of a staff of one or more duly licensed physicians. Services must be provided on its premises or in facilities available to the hospital on a contractual prearranged basis. The institution must provide twenty-four hour a day nursing service by or under the supervision of a Graduate Registered Nurse (R.N.).

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then Constituted or Later Amended.

DEFINITIONS CONTINUED

MEDICARE APPROVED AMOUNTS means the level of service or amount of health care reimbursement recognized and approved for a particular medical or health care service or procedure by Medicare.

MEDICARE ELIGIBLE EXPENSES means health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

NURSE or NURSES means a registered graduate professional nurse (RN), a licensed practical nurse (LPN) or a licensed vocational nurse (LVN).

PHYSICIAN or DOCTOR means any licensed practitioner of the healing arts practicing within the scope of his or her license. The practitioner may not be the Insured Person or a person related to the Insured Person.

PRE-EXISTING CONDITION means the existence of a condition for which medical advice was given or treatment was recommended by or received from a physician and/or medication taken within six(6) months before the effective date of coverage.

SICKNESS means illness or disease of an Insured Person which first manifests itself after the effective date of this insurance and while this coverage is in force.

In the event any definition as defined above is in conflict in whole or in part on the effective date of this policy with any state law or legally adopted regulations of any state in which this policy is issued to a resident of any such state, said definition is hereby amended to comply with the minimum requirements as to that part in conflict with any such regulations or law of any such state and claim will be paid accordingly.

PART A - HOSPITAL INSURANCE BENEFITS

1. HOSPITAL EXPENSE BENEFIT

The Company will pay the following benefits relating to expenses you are responsible for paying when, as a result of such injury or such sickness, an Insured Person is necessarily confined as a resident patient in a hospital and benefits are paid for the confinement by Medicare, Part A.

The Company will provide:

(a) coverage for Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st through the 90th day in any Medicare benefit period.

(b) coverage for Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare, incurred as daily hospital charges during use of Medicare's Lifetime Hospital Inpatient Reserve Days.

(c) upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the Old Surety payment as payment in full and may not bill you for any balance.

2. BLOOD TRANSFUSION BENEFIT

The Company will pay the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulation) received by an Insured Person during any Benefit Period while confined in either a Hospital or Skilled Nursing Facility unless replaced in accordance with federal regulations.

3. HOSPICE CARE BENEFIT

The Company will pay the following benefits relating to expenses you are responsible for paying for Medicare-approved Hospice care.

The Company will provide:

(a) coverage for all copayment amounts you incur for prescription drugs or other similar products approved by Medicare for pain relief and symptom control.

(b) coverage for all coinsurance amounts you incur for Medicare-approved inpatient respite care.

PART B - MEDICAL INSURANCE BENEFITS

1. MEDICAL AND SURGICAL BENEFIT - IN OR OUT OF HOSPITAL

The Company will pay the following benefits relating to expenses you are responsible for paying when, as a result of such injury or such sickness, an Insured Person shall receive medical or surgical treatment from a physician.

The Company will provide:

coverage for the coinsurance amount of Medicare Eligible Expenses under Medicare Part B regardless of hospital confinement.

2. BLOOD TRANSFUSION BENEFIT

The Company will pay the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulation) unless replaced in accordance with federal regulations.

SUSPENSION OF COVERAGE

Benefits and premiums under this policy shall be suspended at the request of the Insured for a period not to exceed twenty-four (24) months in which the Insured has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act (Medicaid), but only if the Insured notifies the Company within ninety (90) days after the date the Insured becomes entitled to such assistance. If suspension occurs and the Insured loses entitlement to such medical assistance, this policy shall be automatically reinstated effective as of the date of termination of entitlement if the Insured provides notice of loss of entitlement to the Company within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

Furthermore benefits and premiums under this policy shall be suspended at the request of the Insured for any period that may be provided by federal regulation if the Insured is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and the Insured loses coverage under the group health plan, this policy shall be automatically reinstated effective as of the date of loss of coverage if the Insured provides notice of loss of coverage to the Company within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

In either case, such automatic reinstatement of the coverage will not be subject to any waiting period regarding any pre-existing condition at the same premium rate as would have been applicable had the coverage not been suspended. Furthermore, the reinstated policy will provide substantially equivalent coverage as provided prior to the date of suspension with the exception of outpatient prescription drugs (*if covered prior to the suspension*) if the Insured is enrolled in Medicare Part D.

LIMITATIONS AND EXCLUSIONS

This policy does not provide any benefits for such injury or such sickness unless such injury of such sickness is of a kind approved for payment by Medicare.

PRE-EXISTING CONDITIONS LIMITATIONS

Pre-Existing Conditions are not covered until this policy has been in force for six (6) months, unless this limitation is waived and so noted on page 2 of the policy on the Schedule I - Policy Information sheet.

All or part of this six (6) month waiting period may be reduced in monthly increments to the extent such waiting period had been satisfied with prior health insurance coverage if proof of such prior creditable coverage is provided to the Company. All of this six (6) month waiting period will be waived if the Insured Person was eligible for this coverage as part of the Guarantee Issue program as detailed in the Guarantee Issue Determination Form made part of the application and provided to the Company.

AUTOMATIC ADJUSTMENT FOR CHANGES IN MEDICARE

If Medicare changes any of its deductible amounts or coinsurance percentage amounts, benefits provided by this policy will automatically adjust to coordinate with such changes. The premium for this policy may also adjust to correspond with these benefit changes.

POLICY PROVISIONS

OWNERSHIP; CONTROL OF POLICY:

This contract is made with the Insured Person who has signed the application herefor and every transaction relating to this policy shall be between the Company and such Insured Person.

PREMIUM PAYMENT:

This policy is issued in consideration of the application therefor, a copy of which is attached hereto and made a part hereof, and the payment in advance of the first premium for the initial term hereof. This policy shall take effect at 12 o'clock noon, Standard Time of the place where the Insured Person resides, and shall remain in effect until the same hour on the date on which the initial term expires. The effective date of this policy, the first premium herefor and the date the initial term expires are shown on page 2 hereof. At the option of the Insured Person, this policy may be continued in force in accordance with and subject to its terms for successive periods by the payment of renewal premiums for the term of 1 month, 3 months, 6 months or 12 months, at the Company's applicable table of rates in effect on the respective due dates of such renewable premiums, but according to the original insuring age of the person covered. All premiums hereunder, except the first premium herefor, shall be due and payable at the Home Office of the Company only in exchange for the Company's Official Receipt signed by the Secretary of the Company.

REFUND OF UNEARNED PREMIUM:

In the event the Insured Person cancels this policy prior to its renewal date, the Company will refund to the Insured Person the unearned premium for any period beyond the end of the policy month in which the cancellation occurred.

In the event of the death of the Insured Person, the Company, upon proper notification, will refund to the estate of the Insured Person the unearned premium for any period beyond the end of the policy month in which the death occurred.

ENTIRE CONTRACT; CHANGES:

This policy, including the endorsements and the attached papers, if any, and the application, a copy of which is attached hereto and made a part hereof, constitute the entire contract of insurance. No change in this policy shall be valid unless approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES:

(a) After two (2) years from the effective date of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of such two (2) year period. (b) No claim for loss incurred commencing after six (6) months after the effective date of this policy shall be reduced or denied on the ground that a disease or physical condition had existed prior to the effective date of coverage of this policy.

GRACE PERIOD:

A grace period of thirty-one days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy will continue in force.

POLICY PROVISIONS
(*continued*)

REINSTATEMENT:

If any renewal premium is not paid within the time granted the Insured for payment, the Company will require an application for reinstatement. The policy will only be reinstated upon approval of such application by the Company or, lacking such approval, upon the thirtieth (30th) day following the date of such application, unless the Company has previously notified the Insured in writing of its disapproval of such application. In all respects the Insured Person and the Company shall have the same rights as they had under the policy immediately before the due date of the defaulted premium. The reinstated policy shall cover all Medicare Eligible Expenses as of the reinstatement effective date. Any premium accepted in connection with the reinstatement shall be applied to the period for which premium has not been previously paid.

NOTICE OF CLAIM:

Written notice of claim must be given to the Company within twenty (20) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Insured Person or the beneficiary to the Company at its Home Office in Oklahoma City, Oklahoma or to any authorized agent of the Company, with information sufficient to identify the Insured Person, shall be deemed notice to the Company.

CLAIM FORMS:

The Company, upon receipt of a notice of claim will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOFS OF LOSS:

Written proof of loss must be furnished to the Company at its Home Office within ninety (90) days after the termination of the period for which the Company is liable. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible or in no event, except in the absence of legal capacity, later that one (1) year from the time proof is otherwise required.

TIME PAYMENT OF CLAIMS:

Indemnities payable under this policy will be paid immediately upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS:

Any accrued indemnity unpaid at the Insured Person’s death may, at the option of the Company, be paid to the estate of the Insured Person. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment. Subject to any written direction of the Insured Person in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the Company's option and unless the Insured Person requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the services be rendered by a particular hospital or person.

POLICY PROVISIONS
(*continued*)

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.

CONFORMITY WITH STATE STATUTES:

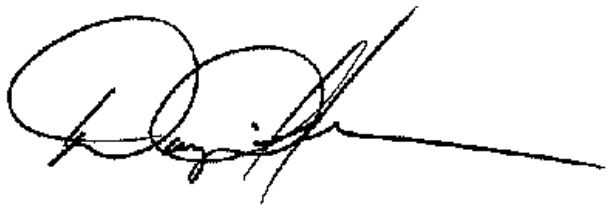
Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the Insured Person resides on such date is hereby amended to conform to the minimum requirements of such statutes.

TERMINATION OF BENEFITS:

Benefits for an Insured Person under this policy end automatically on the earliest of the following dates: the date coverage for the Insured Person is terminated in writing by the Insured Person; the last day for which premium has been paid for the Insured Person; the date this contract for insurance is terminated due to material representation of fraud on the part of the applicant. If a premium is accepted by the Company beyond a specified termination date of benefits for an Insured Person, benefits will continue in force for such Insured Person to the end of such premium payment period.

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 predicated upon the continuous total disability of the Insured Person, 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.

IN WITNESS WHEREOF, Old Surety Life Insurance Company has issued this policy, effective the date shown on the policy schedule page of this policy, in Oklahoma City, Oklahoma.



Secretary

President

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	06/21/2010

Comments:

I do hereby certify this form (Form 600-A-AR) meets the minimum standards as required by ACA 23-80-206.

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	06/21/2010

Comments:

We have removed the reference to a policy fee in the application (page 6). We apologize for the oversight.

Attachment:

2010 Medicare Supp Application AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	06/21/2010

Comments:

Attachment:

2010 Arkansas Medicare Supp Outline.pdf

OLD SURETY LIFE
INSURANCE COMPANY
P.O. BOX 54407 - OKLAHOMA CITY, OK 73154-1407
405-523-2112
Toll Free # 1-800-272-5466
Fax # 1-405-524-4011

"Serving you
- since '32"

Medicare Supplement Application

*** * * WARNING * * ***

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

* This Application Must be Submitted in it's Entirety
- DO NOT REMOVE ANY PAGES -

* A voided check must be obtained if you are applying for a monthly bank draft.

For Use in the State of Arkansas Only

Form MSAP 600 AR

Supplement to Application
For Medicare Supplement Insurance

Guaranteed Issue Eligible persons are those individuals described below who apply to enroll under the policy not later than 63 days after the date of the termination of enrollment and who submit evidence of the date of termination or disenrollment.

Eligible Persons An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan (Group Insurance) that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan (Group Insurance) that 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.

(2) The individual enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of all-inclusive Care for the Elderly (PACE) provider under Section (1894) of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the Individual's enrollment with such provider if such individual enrolled in a Medicare Advantage plan:

(A) The certification of the organization or plan has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or
(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuance of such plan; or
(C) The individual is no longer eligible to elect the plan because of a changed in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851 (g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856, or the plan is terminated for all individuals within a residence area; or
(D) The individual demonstrates, in accordance with guidelines established by the Secretary, that (i) the organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or (ii) the organization, agent or other entity acting on the organization's behalf, materially misrepresented the plan's provision in marketing the plan to the individual; or
(E) The individual meets such other exceptional conditions as the Secretary may provide.

(3) The individual is enrolled with an entity listed in subparagraphs (A) – (D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 3.3312 (b)(2) of this title relating to Guaranteed Issue for Eligible Persons:

(A) An eligible organization under a contract under Section 1876 (Medicare Risk or costs); or
(B) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999: or
(C) An organization under an agreement under Section 1833 (a)(1)(A) (health care prepayment Plan); or
(D) An organization under a Medicare Select policy.

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(A) Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or of other Involuntary termination of coverage or enrollment under the policy; or
(B) The issuer of the policy substantially violated a material provision of the policy, or
(C) The issuer, or an agent or other entity acting on the issuer's behalf materially misrepresented the policy's provision in marketing the policy to the individual.

Supplement to Application For Medicare Supplement Insurance
(continued)

(5) The individual was enrolled under a Medicare Supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract under Section 1876 (Medicare risk or cost), any similar organization operating under demonstration project authority, any PACE organization operating under Section 1894 of the Social Security Act, an organization under an agreement under Section 1833 (a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under Section 1851 (e) of the Social Security Act.

(6) The individual, upon first becoming enrolled in Medicare Part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under Medicare Part C, or in a PACE program under Section 1894 of the Social Security Act, and disenrolls from the plan or program no late than 12 months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.

(8) The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

Creditable Coverage An individual's coverage is creditable if the coverage is provided under:

(A) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 USC Section 1001 et seq.);

(B) a group health benefit plan provided by a health insurance carrier or an HMO;

(C) an individual health insurance policy or evidence of coverage;

(D) Part A or Part B of Title XVIII of the Social Security Act (42 USC Section 1395c et seq.);

(E) Title XIX of the Social Security Act (42 USC Section 1396 et seq.), other than coverage Consisting solely of benefits under Section 1928 of that Act (42 USC Section 1396s);

(E) Chapter 55 of Title 10, United States Code (10 USC Section 1071 et seq.);

(F) a medical care program of the Indian Health Service or of a tribal organization;

(G) a state or political subdivision health benefits risk pool;

(H) a health plan offered under Chapter 89 of Title 5, United States Code (5 USC Section 8901 et seq.)

(I) a public health plan as defined in federal regulation;

(J) a health benefit plan under Section 5(e) of the Peace Corps Act (22 USC Section 2504(e)); and

(K) short-term limited duration insurance.

IMPORTANT ADDITIONAL INFORMATION

You do not need more than one Medicare Supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.

You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for up to 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 reinstituted 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 suspension.

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 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.

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).

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 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 your application.

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.
Please mark YES or NO to each question below with an "X".

1. Did you turn age 65 in the last 6 months? Yes ___ No ___
2. Did you enroll in Medicare Part B in the last 6 months? Yes ___ No ___
   If Yes, what is the effective date? _____
3. 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 payments toward your Medicare Part B premium? Yes ___ No ___
4. 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 dates below. If you are still covered under this plan, leave "END" blank.
   START __/__/____ END __/__/____
   (a) 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 ___
   (b) Was this your first time in this type of Medicare plan? Yes ___ No ___
   (c) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes ___ No ___
5. Do you have another Medicare supplement policy in force? Yes ___ No ___
   (a) If so, with what company, and what plan do you have? _____
   (b) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes ___ No ___
6. 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 this policy, leave "END" blank.
   START __/__/____ END __/__/____

The APPLICANT is to sign here ➔ X_____ *Date* _____

* * * * * * * * * * * * **THE AGENT IS TO ANSWER THE FOLLOWING**:* * * * * * * * * * * *

1. Have you sold any other health insurance policies of coverages to this applicant which are still in force? Yes ___ No ___
   If Yes, list all such coverage _____
2. Have you sold any other health insurance policies or coverages to this applicant in the past 5 years which are no longer in force? Yes ___ No ___
   If Yes, list all such coverage _____

I certify that: 1) I saw the Proposed Insured; 2) I asked the Proposed Insured the questions in the application and truthfully and accurately recorded their answers; 3) their answers did not conflict with my observations and knowledge of the Proposed Insured; 4) I witnessed the Proposed Insured's signatures; & 5) I gave them the Outline of Coverage & *Guide to Health Ins for People with Medicare*.

The AGENT is to sign here ➔ X_____ *Date*_____

**** IMPORTANT * This application is for residents of Arkansas only.***

MEDICARE SUPPLEMENT APPLICATION to OLD SURETY LIFE INSURANCE COMPANY

MODEL PLAN (*check one*)	PAYMENT MODE (*check one*)	BILLING MODE (*check one*)	**Home Office Use Only**
Plan A ☐ Plan A / Disab. ☐ Plan C ☐	Mail ☐ Bank Draft ☐	Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐	

Annual Premium $ _____ Collected with Application $ _____	Special Requests: Requested Effective Date:_____

Proposed Insured:	Sex	Birthdate **Month / Day / Year**	Age	Height	Weight

Residence Address:	**Number**	**Street**	**City**	**State**	**Zip**

Mail Address if other than residence

Home Phone	Cell Phone	E-mail

Premium Payor if other than proposed insured:	**Name**	**Address**

Are you covered by Medicare Part A & B? Yes ☐ No ☐	Medicare Eligibility Date:	Medicare Claim #:

If you qualify for this coverage due to Open Enrollment or as defined in the Guarantee Issue Determination Form, you are not required to answer the following questions.

1. Are you covered under a State Medicaid Program? Yes ☐ No ☐
2. Are you currently Bedridden or Confined to a Hospital, Nursing Facility or a Wheelchair? Yes ☐ No ☐
3. Have you been Hospitalized more than one (1) time in the past two (2) years? Yes ☐ No ☐
4. Have you ever had any Amputation Caused By Disease? Yes ☐ No ☐
5. Do you have only One Kidney or have you ever had or been advised to have Kidney Dialysis? Yes ☐ No ☐
6. Have you ever had a Heart Attack, Angioplasty, Bypass or other Heart or Vascular Surgery? Yes ☐ No ☐
7. In the past two (2) years have you had Diabetes, Cirrhosis of the Liver, Alzheimer's Disease, Addison's Disease, Lou Gehrig's Disease, Crohn's Disease, Lupus, COPD or Emphysema, Mental or Nervous Disorder or been medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)? Yes ☐ No ☐
8. Do you smoke or use tobacco products in any form? Yes ☐ No ☐
9. Do you have a Pacemaker or require Oxygen or Insulin? Yes ☐ No ☐
10. Have you ever been treated for Drug or Alcohol abuse? Yes ☐ No ☐
11. Have you ever been advised that you may require surgery but not had the surgery? Yes ☐ No ☐
12. In the past ten (10) years have you been treated for Internal Cancer or Melanoma or have you had a Stroke? (if Yes, list information below) Yes ☐ No ☐

List Below all other significant Diseases or Disorders you have had which are not listed above.

Description of Sickness or Injury	**Date of Onset**	**Treatment Performed or Scheduled, including dates:**	**Name & Address of Physicians, Hospitals & Nursing Homes**

Continued on Next Page

If you are a Disability Applicant, describe your Disability and list the date your disability began:

Name(s) & Address(es) of the Physician(s) who would have your most current records:	Date last seen?	For what?
1. _____		
2. _____		

LIST BELOW ALL YOUR PRESCRIBED MEDICATIONS INCLUDING DOSAGES

1._____ 2. _____ 3. _____

4._____ 5. _____ 6. _____

List Additional Medical Information, if necessary, in this area.

The following questions regarding existing or prior coverage must be answered!

1. Do you have any Hospital, Medical or Surgical Insurance (including Medicare Supplement or Medicare Advantage coverage) now in force? If YES, give details below: Yes ☐ No ☐

Type of policy _____ Company _____ Policy # _____

2. Will this policy, IF ISSUED, replace a Medicare Supplement plan, an Employee Welfare Benefit Plan, a Medicare Advantage plan, a PACE Plan, a Medicare Select Plan or a Medicare Risk or Cost Plan still in force or which terminated less than 63 days prior to this application? Yes ☐ No ☐

If this question is answered YES, you may qualify for Guarantee Issue of your policy. To make this determination you will need to complete the Guarantee Issue Determination Form.
If you are replacing a Medicare Supplement policy or Medicare Advantage coverage you will also need to complete the "Notice to Applicant Regarding Replacement" form.

AGREEMENT: The undersigned person represents that the answers given herein are true and correct according to the best of his/her knowledge and belief and further understands that the insurance applied for will not become effective until the policy is issued and actually delivered to the owner while the proposed insured is in the same condition of health as described in the foregoing application and the first premium has been paid.

**** IMPORTANT ****

If your policy is issued it will contain a six (6) month waiting period on pre-existing conditions unless you provide proof you are replacing creditable coverage. If you qualify as an eligible person the waiting period will be waived.

I hereby acknowledge receipt of the following information: (*check applicable items*)

Outline of Coverage ☐ Buyer's Guide ☐
Replacement Notification ☐ Supplemental Application for Medicare Supplement Insurance ☐

Dated this _____ day of _____, _____ at _____
day month year city / state

_____ _____ _____
Writing Agent Agent # Signature of Proposed Insured

Authorization for Release of Personal Health Information

Patient Information :

Name _____ Date of Birth _____ Social Security # _____
(First, Middle Initial, Last)

Information to be released from: _____
Name of designated Facility or Provider

_____
Street address or other Mailing Address

_____
City, State, Zip Code

Information to be sent to:

Old Surety Life Insurance Company
P O Box 54407
Oklahoma City OK 73154

1-800-272-5466

Information to be released:

☐ The most recent five (5) years of pertinent information (i.e. chart notes, labs, x-rays and special tests)
☐ Specify Information (Please specify): _____

Purpose for which disclosure is being made: Medicare Supplement Insurance Application

Patient Authorization:
I understand that the medical information released by this authorization may include information concerning the diagnosis or treatment of HIV / AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I understand that I am authorizing the release of this information and that if I choose I may exclude the release of the following items by initialing the to the left of the category I choose to exclude.

I wish to EXCLUDE the following information from the records to be released (please initial);
___ Drug / Alcohol abuse / treatment & diagnosis ___ Sexually Transmitted Disease
___ HIV / AIDS diagnosis / treatment / testing ___ Mental Illness or Psychiatric diagnosis / treatment

I understand this authorization will expire, without my express revocation, one year from the date of signing, unless otherwise limited below, or if I am a minor, on the date I become an adult according to state law. I understand I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
I hereby limit this authorization to _____ days (*365 days unless otherwise limited)*

I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that I do not have to sign this authorization to obtain health care benefits, treatment, payment or enrollment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules. I understand that Old Surety Life Insurance Company will take appropriate measures to maintain the confidentiality and privacy of this information as provided by law.

A copy of this authorization is as valid as the original.

Signature: _____ **Date** _____
Signature of Proposed Insured

OLD SURETY LIFE INSURANCE COMPANY
GUARANTEE ISSUE DETERMINATION FORM

Applicant's name: _____ **Medicare ID #:** _____

This Guarantee Issue Determination form will determine if you are eligible for guarantee issue other than the Open Enrollment period that is offered when you first become eligible for Medicare Part B benefits. In order to determine your eligibility for this additional sixty-three (63) day guarantee issue period you must provide certain information and documentation of termination or disenrollment in certain Medicare or Medicare Supplement coverage. Evidence of termination or disenrollment must be attached to this form.

*NOTE: THE APPLICATION MUST BE RECEIVED AT THE HOME OFFICE OF OLD SURETY WITHIN THE SIXTY-THREE (63) DAY PERIOD AND APPROPRIATE DOCUMENTATION PROVIDED WITHIN THIRTY (30) DAYS.

Complete the Section Below Which Describes Your Prior Health Care Coverage

EMPLOYEE WELFARE BENEFIT PLAN

Within the past 63 days were you notified the employee welfare benefit plan you were enrolled in that provided health benefits that supplement the benefits under Medicare had been terminated, or that the plan ceased to provide some or all such supplemental health benefits, or the employee welfare benefit plan that you were enrolled in that was primary to Medicare had been terminated or that the plan ceased to provide some or all such supplemental health benefits, or did you leave the plan whether the plan is primary or secondary to Medicare?

Yes ☐ No ☐

If YES you are eligible for Guarantee Issue.

or

MEDICARE ADVANTAGE PLAN

When you first became eligible for Medicare Part B benefits at age 65 or older did you enroll in a Medicare Advantage Plan from which you disenrolled within the first 12 months of coverage and within the past 63 days? Yes ☐ No ☐

If YES you are eligible for Guarantee Issue.

or

MEDICARE SELECT PLAN, MEDICARE RISK or COST PLAN, P.A.C.E. PROGRAM or a MEDICARE ADVANTAGE PLAN

1. Within the past 12 months did you terminate Medicare Supplement coverage to enroll in a Medicare Select Program a Medicare Risk or Cost Plan, a P.A.C.E. Plan or a Medicare Advantage plan? Yes ☐ No ☐

   If YES complete the following regarding your prior Medicare Supplement coverage:

   Company Name _____ Policy/Certificate # _____

2. Within the past 63 days did you terminate your Medicare Select Plan, Medicare Risk or Cost Plan, a P.A.C.E. Program or a Medicare Advantage plan? Yes ☐ No ☐

   If you answered YES to questions 1 & 2 you are eligible for Guarantee Issue with the plan you previously had. You must contact your prior Medicare Supplement insurer to reenroll in your previous plan. If reenrollment in your previous plan is not available, you are eligible for Guarantee Issue with this company.

3. Within the past 63 days did your Medicare Select Plan, Medicare Risk of Cost Plan, P.A.C.E. Program or Medicare Advantage Plan terminate for one of the following reasons:
   a. the plan's certification terminated? Yes ☐ No ☐
   b. the plan's coverage terminated in your area? Yes ☐ No ☐
   c. your residence changed to an area not covered by the plan? Yes ☐ No ☐
   d. the provider substantially violated a material provision of the plan such as the failure to provide on a timely basis medically necessary care for which benefits are available or failure to provide such covered care in accordance with applicable quality standards? Yes ☐ No ☐
   e. the plan, agent or other entity acting on behalf of the plan, materially misrepresented the plan's provision in marketing the plan to you? Yes ☐ No ☐
   f. other exceptional conditions for the termination of the plan? Yes ☐ No ☐

If YES you are eligible for Guarantee Issue.

(continued on next page)

OLD SURETY LIFE INSURANCE COMPANY
GUARANTEE ISSUE DETERMINATION FORM
(*continued*)

or

MEDICARE SUPPLEMENT POLICY

Within the past 63 days did your Medicare Supplement Policy terminate for one of the following reasons:

a. insolvency or bankruptcy of the insuring company, or of other involuntary termination of coverage or enrollment under the policy? Yes ☐ No ☐
b. the issuing company substantially violated a material provision of the policy? Yes ☐ No ☐
c. the issuing company, agent or other entity acting on behalf of the plan, materially misrepresented the policy's provision in marketing the plan to you? Yes ☐ No ☐
d. involuntary termination of coverage or enrollment? Yes ☐ No ☐

*NOTE: An increase in premium does not constitute a violation of a material provision of the policy or material representation of the policy.

If YES you are eligible for Guarantee Issue.

or

ENROLLMENT IN A MEDICARE PART D PLAN

Within the past 63 days did you enroll in a Medicare Part D plan during your initial enrollment period and, at the time of enrollment in Part D, terminate your Medicare Supplement coverage which provided coverage for outpatient prescription drugs? Yes ☐ No ☐

If YES you are eligible for Guarantee Issue with the company that issued your prior Medicare Supplement coverage, however you must provide evidence of enrollment in Medicare Part D along with the application.

or

MEDICAID

Have you been notified of your loss of eligibility for health benefits under Title XIX of the Social Security Act (Medicaid) within the past 63 days? Yes ☐ No ☐

If YES you are eligible for Guarantee Issue.

If you answered YES to any of the questions you must attach the appropriate documentation that indicates the date and reason of the termination of coverage. The company terminating your plan is required to notify you in writing of the termination of the plan and the reason for termination.

I understand this Guarantee Issue form will become a part of my application for coverage and that Old Surety may investigate my responses to the questions. I further understand that any documentation provided is also subject to review and investigation.

_____ _____
Applicant's Signature Date

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE or MEDICARE ADVANTAGE

OLD SURETY LIFE INSURANCE COMPANY
5235 N. Lincoln - P. O. Box 54407, Oklahoma City, OK 73154
405-523-2112 - Toll Free # 1-800-272-5466

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage coverage and replace it with a policy to be issued by Old Surety Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY AGENT

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy (if issued) will not duplicate your existing Medicare supplement coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s):

(*please check one*)

_____ Additional benefits
_____ Same benefits, but lower premiums
_____ Fewer benefits and lower premiums
_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D,
_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____ Other (please specify)

_____

I call to your attention the following items for your consideration.

Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy to the extent such time was spent under the original policy.

(continued on next page)

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the issuer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

* * * * * *

_____

(agent's signature)

Type or print name and address of Agent or Broker:

_____

_____

_____

* * * * * *

The above "Notice to applicant …" was delivered to me on

_____

(*date***)**

_____

(*applicant's signature***)**

PREMIUM PAYOR AUTHORIZATION AGREEMENT FOR PRE-ARRANGED PAYMENTS (DEBITS)
(Please attach a voided check)

I hereby authorize Old Surety Life Insurance Company to debit / charge my account indicated below.

CHECKING ACCOUNT	SAVINGS ACCOUNT	ACCOUNT #
☐ (Check here for Checking)	☐ (Check here for Savings)	_____ (Enter Account Number here)

BANK NAME

_____

BANK ADDRESS

_____

This authority is to remain in force and effect until the Company has received written notification from me of its termination in such time and in such manner as to afford Company a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notification to Company prior to charging account. The customer has the right to return an item up to 60 days after the charge date if the customer feels that the transaction was not authorized or if the customer is revoking the authorization. In the case of ACH or Electronic Funds Transfer, Old Surety Life Insurance Company indemnifies the receiving financial institution through the National Automated Clearing House Association and local Automated Clearing House Association rules.

SIGNATURE _____

NAME _____
(Print Premium Payor Name)

DATE _____

To: The Bank Named Above:
So that you may comply with your depositor's request this Company agrees:

1. 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 Pre-Authorized Check Plan payment, including any costs or expenses reasonably incurred in connection therewith.
2. 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 any loss even though dishonor results in a forfeiture of the insurance.
3. 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 the foregoing request, or in any manner arising by reason of your participation in the foregoing plan.

Dale L. Phillips
DALE L. PHILLIPS, President

OLD SURETY LIFE INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA
Authorized in a resolution adopted by the Board of Directors of the Old Surety Life Insurance Company, Oklahoma City, Oklahoma on July 27, 1998.

Please attach a voided check here.
↓

Arkansas

OLD SURETY LIFE INSURANCE COMPANY

2010 **

(effective 06/01/2010)

Outline of Medicare Supplement Coverage

Benefit Plans A and C Only are being offered by the company at this time.

Benefit Plan A only is available to individuals on Medicare by reason of disability who reside in Arkansas.

These charts show the benefits included in each of the standard Medicare supplement plans.

Every company must make available Plan "A". Some plans may not be available in your state.

Plan E, H, I and J are no longer available for sale.

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 days after Medicare approved expenses), or co-payments for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B coinsurance or copayments.

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 $[4,620]; paid at 100% after limit reached	**Out-of pocket limit $[2,310]; paid at 100% after limit reached**		

* Plan 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 [$ 2,000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$ 2,000]. 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.

OLD SURETY LIFE INSURANCE COMPANY

P.O. Box 54407 OKC, OK 73154 1-800-272-5466

2010 MEDICARE SUPPLEMENT RATES for ARKANSAS

(Effective 6-1-2010)

Plan A

Area 1	Annual	Semi-Annual	Quarterly	Monthly	Monthly Draft
zip codes beginning with 722	$1,500.00	$750.00	$375.00	$137.50	$125.00

Area 2	Annual	Semi-Annual	Quarterly	Monthly	Monthly Draft
zip codes beginning with 720-721	$1,380.00	$690.00	$345.00	$126.50	$115.00

Area 3	Annual	Semi-Annual	Quarterly	Monthly	Monthly Draft
All other zip codes	$1,260.00	$630.00	$315.00	$115.50	$105.00

TOBACCO USE - ADD 10% to premium mode selected

Plan C

Area 1	Annual	Semi-Annual	Quarterly	Monthly	Monthly Draft
zip codes beginning with 722	$1,620.00	$810.00	$405.00	$148.50	$135.00

Area 2	Annual	Semi-Annual	Quarterly	Monthly	Monthly Draft
zip codes beginning with 720-721	$1,500.00	$750.00	$375.00	$137.50	$125.00

Area 3	Annual	Semi-Annual	Quarterly	Monthly	Monthly Draft
All other zip codes	$1,380.00	$690.00	$345.00	$126.50	$115.00

TOBACCO USE - ADD 10% to premium mode selected

PREMIUM INFORMATION

We, OLD SURETY LIFE INS. CO. can only raise your premium if we raise the premium for all policies like yours in this state.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

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 Old Surety Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to **Old Surety Life Insurance Company, P.O. Box 54407, Oklahoma City, OK 73154**. 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 or other health coverage, DO NOT cancel it until you have actually received you new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Old Surety Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact you local Social Security Office or consult "*The Medicare Handbook*" for more details.

PRE-EXISTING CONDITION LIMITATIONS

Your policy with Old Surety, if issued, will contain a six month waiting period on pre-existing conditions, as defined in the policy, <u>if</u> you are not replacing an existing Medicare Supplement policy or other Creditable Coverage. If you are replacing existing Medicare Supplement or other Creditable Coverage, Old Surety will waive the pre-existing waiting period to the extent it was satisfied with the coverage you are replacing.

Under certain circumstances you may be eligible for Guarantee Issue of your policy if you are replacing an Employee Welfare Benefit Plan, a Medicare Advantage Plan, a PACE plan, a Medicare Select Plan, a Medicare Risk or Cost Plan or a Medicare Supplement plan for which your coverage terminated and you experienced loss of coverage for 63 days or less. For more details see the Guarantee Issue Determination Form which is made a part of the application. If you qualify for the Guarantee Issue, Old Surety will waive the Pre-Existing Condition waiting period.

REFUND OF PREMIUM

Your policy, if issued, will not contain a provision for refund of premium after the initial 30-day "Right to Return Policy" period. In the event you cancel this policy prior to its renewal date, Old Surety will refund the unearned premium for any period beyond the end of the policy month in which the cancellation occurred. In the event of your death, Old Surety, upon proper notification, will refund to your estate the unearned premium for any period beyond the end of the policy month in which the death occurred.

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.

** * * Medicare Supplement - Plan A (Core Policy) * * **

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

* A benefit period begins on the first day you receive services 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but [$ 1,100]	$ 0	[$ 1,100] Part A Deductible
61st through 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 & entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$ 0	$ 0**
21st through 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 outpatient drugs and inpatient respite care	Medicare copayment / 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 an additional 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.

** * * Medicare Supplement – Plan A (Core Policy) * * **

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) you Part B Deductible will have been met for the calendar year.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL & OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient & outpatient medical & surgical services & supplies, physical & speech therapy, diagnostic test, 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 - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0**

– ************* MEDICARE (PARTS A <u>and</u> B) *************

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**

* * * Medicare Supplement - Plan C * * *

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

* A benefit period begins on the first day you receive services 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but [$ 1,100]	[$ 1,100] Part A Deductible	$ 0**
61st through 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 & entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$ 0	$ 0**
21st through 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 outpatient drugs and inpatient respite care	Medicare copayment / 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 an additional 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.

*** Medicare Supplement - Plan C ***

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) you Part B Deductible will have been met for the calendar year.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL & OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient & outpatient medical & surgical services & supplies, physical & speech therapy, diagnostic test, 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	$ 0	All Costs
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 - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0**
********** MEDICARE (PARTS A and B) **********			
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**
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 max.

NOTE PAGE

* * * * * * * * * * * * RECEIPT * * * * * * * * * * * *

Received of _____the sum of $_____for Plan _____

If for any reason the application is not approved and contract issued, this payment is to be refunded. No liability is created or assumed by the Company except for refund of this payment, until the contract applied for has been delivered and accepted by the owner during the insured's lifetime while health of the proposed insured remains as described in the application. If you do not receive your contract within sixty (60) days from the date of application, please write to:

OLD SURETY LIFE INSURANCE COMPANY
P. O. BOX 54407 - OKLAHOMA CITY, OKLAHOMA 73154

_____	_____	_____
Dated at	Date	Authorized Representative

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE or MEDICARE ADVANTAGE

OLD SURETY LIFE INSURANCE COMPANY
5235 N. Lincoln - P. O. Box 54407, Oklahoma City, OK 73154
405-523-2112 - Toll Free # 1-800-272-5466

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage coverage and replace it with a policy to be issued by Old Surety Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY AGENT

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy (if issued) will not duplicate your existing Medicare supplement coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s):

(please check one)

____ Additional benefits
____ Same benefits, but lower premiums
____ Fewer benefits and lower premiums
____ My plan has outpatient prescription drug coverage and I am enrolling in Part D,
____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

____ Other (please specify)

_____

I call to your attention the following items for your consideration.

Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy to the extent such time was spent under the original policy.

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the issuer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

*** * * * * ***

_____
(agent's signature)

Type or print name and address of Agent or Broker:

_____

_____

_____

* * * * * *

The above "Notice to applicant …" was delivered to me on

_____
(date)

_____
(applicant's signature)

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/30/2010	Supporting Document	Application	06/15/2010	2010 Medicare Supp Application-AR.pdf (Superceded)

OLD SURETY LIFE
INSURANCE COMPANY
P.O. BOX 54407 - OKLAHOMA CITY, OK 73154-1407
405-523-2112
Toll Free # 1-800-272-5466
Fax # 1-405-524-4011

"Serving you
- since '32"

Medicare Supplement Application

*** * * WARNING * * ***

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

* This Application Must be Submitted in it's Entirety
- DO NOT REMOVE ANY PAGES -

* A voided check must be obtained if you are applying for a monthly bank draft.

For Use in the State of Arkansas Only

Form MSAP 600 AR

Supplement to Application
For Medicare Supplement Insurance

Guaranteed Issue Eligible persons are those individuals described below who apply to enroll under the policy not later than 63 days after the date of the termination of enrollment and who submit evidence of the date of termination or disenrollment.

Eligible Persons An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan (Group Insurance) that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan (Group Insurance) that 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.

(2) The individual enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of all-inclusive Care for the Elderly (PACE) provider under Section (1894) of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the Individual's enrollment with such provider if such individual enrolled in a Medicare Advantage plan:

(A) The certification of the organization or plan has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or
(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuance of such plan; or
(C) The individual is no longer eligible to elect the plan because of a changed in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851 (g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856, or the plan is terminated for all individuals within a residence area; or
(D) The individual demonstrates, in accordance with guidelines established by the Secretary, that (i) the organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or (ii) the organization, agent or other entity acting on the organization's behalf, materially misrepresented the plan's provision in marketing the plan to the individual; or
(E) The individual meets such other exceptional conditions as the Secretary may provide.

(3) The individual is enrolled with an entity listed in subparagraphs (A) – (D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 3.3312 (b)(2) of this title relating to Guaranteed Issue for Eligible Persons:

(A) An eligible organization under a contract under Section 1876 (Medicare Risk or costs); or
(B) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999: or
(C) An organization under an agreement under Section 1833 (a)(1)(A) (health care prepayment Plan); or
(D) An organization under a Medicare Select policy.

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(A) Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or of other Involuntary termination of coverage or enrollment under the policy; or
(B) The issuer of the policy substantially violated a material provision of the policy, or
(C) The issuer, or an agent or other entity acting on the issuer's behalf materially misrepresented the policy's provision in marketing the policy to the individual.

Supplement to Application For Medicare Supplement Insurance
(continued)

(5) The individual was enrolled under a Medicare Supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract under Section 1876 (Medicare risk or cost), any similar organization operating under demonstration project authority, any PACE organization operating under Section 1894 of the Social Security Act, an organization under an agreement under Section 1833 (a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under Section 1851 (e) of the Social Security Act.

(6) The individual, upon first becoming enrolled in Medicare Part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under Medicare Part C, or in a PACE program under Section 1894 of the Social Security Act, and disenrolls from the plan or program no late than 12 months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.

(8) The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

Creditable Coverage An individual's coverage is creditable if the coverage is provided under:

(A) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 USC Section 1001 et seq.);

(B) a group health benefit plan provided by a health insurance carrier or an HMO;

(C) an individual health insurance policy or evidence of coverage;

(D) Part A or Part B of Title XVIII of the Social Security Act (42 USC Section 1395c et seq.);

(E) Title XIX of the Social Security Act (42 USC Section 1396 et seq.), other than coverage Consisting solely of benefits under Section 1928 of that Act (42 USC Section 1396s);

(E) Chapter 55 of Title 10, United States Code (10 USC Section 1071 et seq.);

(F) a medical care program of the Indian Health Service or of a tribal organization;

(G) a state or political subdivision health benefits risk pool;

(H) a health plan offered under Chapter 89 of Title 5, United States Code (5 USC Section 8901 et seq.)

(I) a public health plan as defined in federal regulation;

(J) a health benefit plan under Section 5(e) of the Peace Corps Act (22 USC Section 2504(e)); and

(K) short-term limited duration insurance.

IMPORTANT ADDITIONAL INFORMATION

You do not need more than one Medicare Supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.

You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for up to 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 reinstituted 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 suspension.

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 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.

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).

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 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 your application.

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.
Please mark YES or NO to each question below with an "X".

1. Did you turn age 65 in the last 6 months? Yes ___ No ___
2. Did you enroll in Medicare Part B in the last 6 months? Yes ___ No ___
   If Yes, what is the effective date? _____
3. 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 payments toward your Medicare Part B premium? Yes ___ No ___
4. 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 dates below. If you are still covered under this plan, leave "END" blank.
   START __/__/____ END __/__/____
   (a) 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 ___
   (b) Was this your first time in this type of Medicare plan? Yes ___ No ___
   (c) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes ___ No ___
5. Do you have another Medicare supplement policy in force? Yes ___ No ___
   (a) If so, with what company, and what plan do you have? _____
   (b) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes ___ No ___
6. 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 this policy, leave "END" blank.
   START __/__/____ END __/__/____

The APPLICANT is to sign here ➔ *X* _____ *Date* _____

* * * * * * * * * * * * **THE AGENT IS TO ANSWER THE FOLLOWING**:* * * * * * * * * * * *

1. Have you sold any other health insurance policies of coverages to this applicant which are still in force? Yes ___ No ___
   If Yes, list <u>all</u> such coverage _____

2. Have you sold any other health insurance policies or coverages to this applicant in the past 5 years which are no longer in force? Yes ___ No ___
   If Yes, list <u>all</u> such coverage _____

I certify that: 1) I saw the Proposed Insured; 2) I asked the Proposed Insured the questions in the application and truthfully and accurately recorded their answers; 3) their answers did not conflict with my observations and knowledge of the Proposed Insured; 4) I witnessed the Proposed Insured's signatures; & 5) I gave them the Outline of Coverage & *Guide to Health Ins for People with Medicare*.

The AGENT is to sign here ➔ *X* _____ *Date* _____

**** IMPORTANT * This application is for residents of Arkansas only.***

MEDICARE SUPPLEMENT APPLICATION to OLD SURETY LIFE INSURANCE COMPANY

MODEL PLAN (*check one*)	PAYMENT MODE (*check one*)	BILLING MODE (*check one*)	**Home Office Use Only**
Plan A ☐ Plan A / Disab. ☐ Plan C ☐	Mail ☐ Bank Draft ☐	Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐	

Mode Premium $ _____ Policy Fee $ $ 20.00 TOTAL $ _____	Special Requests: Requested Effective Date:_____

Proposed Insured:	Sex	Birthdate **Month / Day / Year**	Age	Height	Weight

Residence Address:	**Number**	**Street**	**City**	**State**	**Zip**

Mail Address if other than residence

Home Phone	Cell Phone	E-mail

Premium Payor if other than proposed insured:	**Name**	**Address**

Are you covered by Medicare Part A & B?	Medicare Eligibility Date:	Medicare Claim #:
Yes ☐ No ☐		

If you qualify for this coverage due to Open Enrollment or as defined in the Guarantee Issue Determination Form, you are not required to answer the following questions.

1. Are you covered under a State Medicaid Program? Yes ☐ No ☐
2. Are you currently Bedridden or Confined to a Hospital, Nursing Facility or a Wheelchair? Yes ☐ No ☐
3. Have you been Hospitalized more than one (1) time in the past two (2) years? Yes ☐ No ☐
4. Have you ever had any Amputation Caused By Disease? Yes ☐ No ☐
5. Do you have only One Kidney or have you ever had or been advised to have Kidney Dialysis? Yes ☐ No ☐
6. Have you ever had a Heart Attack, Angioplasty, Bypass or other Heart or Vascular Surgery? Yes ☐ No ☐
7. In the past two (2) years have you had Diabetes, Cirrhosis of the Liver, Alzheimer's Disease, Addison's Disease, Lou Gehrig's Disease, Crohn's Disease, Lupus, COPD or Emphysema, Mental or Nervous Disorder or been medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)? Yes ☐ No ☐
8. Do you smoke or use tobacco products in any form? Yes ☐ No ☐
9. Do you have a Pacemaker or require Oxygen or Insulin? Yes ☐ No ☐
10. Have you ever been treated for Drug or Alcohol abuse? Yes ☐ No ☐
11. Have you ever been advised that you may require surgery but not had the surgery? Yes ☐ No ☐
12. In the past ten (10) years have you been treated for Internal Cancer or Melanoma or have you had a Stroke? (if Yes, list information below) Yes ☐ No ☐

List Below all other significant Diseases or Disorders you have had which are not listed above.

Description of Sickness or Injury	**Date of Onset**	**Treatment Performed or Scheduled, including dates:**	**Name & Address of Physicians, Hospitals & Nursing Homes**

Continued on Next Page

If you are a Disability Applicant, describe your Disability and list the date your disability began:

Name(s) & Address(es) of the Physician(s) who would have your most current records:	Date last seen?	For what?
1. _____		
2. _____		

LIST BELOW ALL YOUR PRESCRIBED MEDICATIONS INCLUDING DOSAGES

1._____ 2. _____ 3. _____

4._____ 5. _____ 6. _____

List Additional Medical Information, if necessary, in this area.

The following questions regarding existing or prior coverage must be answered!

1. Do you have any Hospital, Medical or Surgical Insurance (including Medicare Supplement or Medicare Advantage coverage) now in force? If YES, give details below: Yes ☐ No ☐

Type of policy _____ Company _____ Policy # _____

2. Will this policy, IF ISSUED, replace a Medicare Supplement plan, an Employee Welfare Benefit Plan, a Medicare Advantage plan, a PACE Plan, a Medicare Select Plan or a Medicare Risk or Cost Plan still in force or which terminated less than 63 days prior to this application? Yes ☐ No ☐

If this question is answered YES, you may qualify for Guarantee Issue of your policy. To make this determination you will need to complete the Guarantee Issue Determination Form.
If you are replacing a Medicare Supplement policy or Medicare Advantage coverage you will also need to complete the "Notice to Applicant Regarding Replacement" form.

AGREEMENT: The undersigned person represents that the answers given herein are true and correct according to the best of his/her knowledge and belief and further understands that the insurance applied for will not become effective until the policy is issued and actually delivered to the owner while the proposed insured is in the same condition of health as described in the foregoing application and the first premium has been paid.

**** IMPORTANT ****

If your policy is issued it will contain a six (6) month waiting period on pre-existing conditions unless you provide proof you are replacing creditable coverage. If you qualify as an eligible person the waiting period will be waived.

I hereby acknowledge receipt of the following information: (*check applicable items*)

Outline of Coverage ☐ Buyer's Guide ☐
Replacement Notification ☐ Supplemental Application for Medicare Supplement Insurance ☐

Dated this _____ day of _____, _____ at _____
day month year city / state

_____ _____ _____
Writing Agent Agent # Signature of Proposed Insured

Authorization for Release of Personal Health Information

Patient Information :

Name _____ Date of Birth _____ Social Security # _____
(First, Middle Initial, Last)

Information to be released from: _____
Name of designated Facility or Provider

_____
Street address or other Mailing Address

_____
City, State, Zip Code

Information to be sent to:

Old Surety Life Insurance Company
P O Box 54407
Oklahoma City OK 73154

1-800-272-5466

Information to be released:

- ☐ The most recent five (5) years of pertinent information (i.e. chart notes, labs, x-rays and special tests)
- ☐ Specify Information (Please specify): _____

Purpose for which disclosure is being made: Medicare Supplement Insurance Application

Patient Authorization:

I understand that the medical information released by this authorization may include information concerning the diagnosis or treatment of HIV / AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I understand that I am authorizing the release of this information and that if I choose I may exclude the release of the following items by initialing the to the left of the category I choose to exclude.

I wish to EXCLUDE the following information from the records to be released (please initial);

___ Drug / Alcohol abuse / treatment & diagnosis ___ Sexually Transmitted Disease
___ HIV / AIDS diagnosis / treatment / testing ___ Mental Illness or Psychiatric diagnosis / treatment

I understand this authorization will expire, without my express revocation, one year from the date of signing, unless otherwise limited below, or if I am a minor, on the date I become an adult according to state law. I understand I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

I hereby limit this authorization to _____ days (*365 days unless otherwise limited)*

I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that I do not have to sign this authorization to obtain health care benefits, treatment, payment or enrollment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules. I understand that Old Surety Life Insurance Company will take appropriate measures to maintain the confidentiality and privacy of this information as provided by law.

A copy of this authorization is as valid as the original.

Signature: _____ **Date** _____
Signature of Proposed Insured

OLD SURETY LIFE INSURANCE COMPANY
GUARANTEE ISSUE DETERMINATION FORM

Applicant's name: _____ **Medicare ID #:** _____

This Guarantee Issue Determination form will determine if you are eligible for guarantee issue other than the Open Enrollment period that is offered when you first become eligible for Medicare Part B benefits. In order to determine your eligibility for this additional sixty-three (63) day guarantee issue period you must provide certain information and documentation of termination or disenrollment in certain Medicare or Medicare Supplement coverage. Evidence of termination or disenrollment must be attached to this form.

*NOTE: THE APPLICATION MUST BE RECEIVED AT THE HOME OFFICE OF OLD SURETY WITHIN THE SIXTY-THREE (63) DAY PERIOD AND APPROPRIATE DOCUMENTATION PROVIDED WITHIN THIRTY (30) DAYS.

Complete the Section Below Which Describes Your Prior Health Care Coverage

EMPLOYEE WELFARE BENEFIT PLAN

Within the past 63 days were you notified the employee welfare benefit plan you were enrolled in that provided health benefits that supplement the benefits under Medicare had been terminated, or that the plan ceased to provide some or all such supplemental health benefits, or the employee welfare benefit plan that you were enrolled in that was primary to Medicare had been terminated or that the plan ceased to provide some or all such supplemental health benefits, or did you leave the plan whether the plan is primary or secondary to Medicare?

Yes ☐ No ☐

If YES you are eligible for Guarantee Issue.

or

MEDICARE ADVANTAGE PLAN

When you first became eligible for Medicare Part B benefits at age 65 or older did you enroll in a Medicare Advantage Plan from which you disenrolled within the first 12 months of coverage and within the past 63 days? Yes ☐ No ☐

If YES you are eligible for Guarantee Issue.

or

MEDICARE SELECT PLAN, MEDICARE RISK or COST PLAN, P.A.C.E. PROGRAM or a MEDICARE ADVANTAGE PLAN

1. Within the past 12 months did you terminate Medicare Supplement coverage to enroll in a Medicare Select Program a Medicare Risk or Cost Plan, a P.A.C.E. Plan or a Medicare Advantage plan? Yes ☐ No ☐

   If YES complete the following regarding your prior Medicare Supplement coverage:

   Company Name _____ Policy/Certificate # _____

2. Within the past 63 days did you terminate your Medicare Select Plan, Medicare Risk or Cost Plan, a P.A.C.E. Program or a Medicare Advantage plan? Yes ☐ No ☐

   If you answered YES to questions 1 & 2 you are eligible for Guarantee Issue with the plan you previously had. You must contact your prior Medicare Supplement insurer to reenroll in your previous plan. If reenrollment in your previous plan is not available, you are eligible for Guarantee Issue with this company.

3. Within the past 63 days did your Medicare Select Plan, Medicare Risk of Cost Plan, P.A.C.E. Program or Medicare Advantage Plan terminate for one of the following reasons:
   a. the plan's certification terminated? Yes ☐ No ☐
   b. the plan's coverage terminated in your area? Yes ☐ No ☐
   c. your residence changed to an area not covered by the plan? Yes ☐ No ☐
   d. the provider substantially violated a material provision of the plan such as the failure to provide on a timely basis medically necessary care for which benefits are available or failure to provide such covered care in accordance with applicable quality standards? Yes ☐ No ☐
   e. the plan, agent or other entity acting on behalf of the plan, materially misrepresented the plan's provision in marketing the plan to you? Yes ☐ No ☐
   f. other exceptional conditions for the termination of the plan? Yes ☐ No ☐

If YES you are eligible for Guarantee Issue.

(continued on next page)

OLD SURETY LIFE INSURANCE COMPANY
GUARANTEE ISSUE DETERMINATION FORM
(*continued)*

or

MEDICARE SUPPLEMENT POLICY

Within the past 63 days did your Medicare Supplement Policy terminate for one of the following reasons:

a. insolvency or bankruptcy of the insuring company, or of other involuntary termination of coverage or enrollment under the policy? Yes ☐ No ☐
b. the issuing company substantially violated a material provision of the policy? Yes ☐ No ☐
c. the issuing company, agent or other entity acting on behalf of the plan, materially misrepresented the policy's provision in marketing the plan to you? Yes ☐ No ☐
d. involuntary termination of coverage or enrollment? Yes ☐ No ☐

*NOTE: An increase in premium does not constitute a violation of a material provision of the policy or material representation of the policy.

If YES you are eligible for Guarantee Issue.

or

ENROLLMENT IN A MEDICARE PART D PLAN

Within the past 63 days did you enroll in a Medicare Part D plan during your initial enrollment period and, at the time of enrollment in Part D, terminate your Medicare Supplement coverage which provided coverage for outpatient prescription drugs? Yes ☐ No ☐

If YES you are eligible for Guarantee Issue with the company that issued your prior Medicare Supplement coverage, however you must provide evidence of enrollment in Medicare Part D along with the application.

or

MEDICAID

Have you been notified of your loss of eligibility for health benefits under Title XIX of the Social Security Act (Medicaid) within the past 63 days? Yes ☐ No ☐

If YES you are eligible for Guarantee Issue.

If you answered YES to any of the questions you must attach the appropriate documentation that indicates the date and reason of the termination of coverage. The company terminating your plan is required to notify you in writing of the termination of the plan and the reason for termination.

I understand this Guarantee Issue form will become a part of my application for coverage and that Old Surety may investigate my responses to the questions. I further understand that any documentation provided is also subject to review and investigation.

_____ _____
Applicant's Signature Date

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE or MEDICARE ADVANTAGE

OLD SURETY LIFE INSURANCE COMPANY
5235 N. Lincoln - P. O. Box 54407, Oklahoma City, OK 73154
405-523-2112 - Toll Free # 1-800-272-5466

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage coverage and replace it with a policy to be issued by Old Surety Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY AGENT

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy (if issued) will not duplicate your existing Medicare supplement coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s):

(*please check one*)

____ Additional benefits
____ Same benefits, but lower premiums
____ Fewer benefits and lower premiums
____ My plan has outpatient prescription drug coverage and I am enrolling in Part D,
____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

____ Other (please specify)

_____

I call to your attention the following items for your consideration.

Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy to the extent such time was spent under the original policy.

(continued on next page)

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the issuer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

*** * * * * ***

_____

(agent's signature)

Type or print name and address of Agent or Broker:

_____

_____

_____

*** * * * * ***

The above "Notice to applicant …" was delivered to me on

_____

(*date***)**

_____

(*applicant's signature***)**

PREMIUM PAYOR AUTHORIZATION AGREEMENT FOR PRE-ARRANGED PAYMENTS (DEBITS)
(Please attach a voided check)

I hereby authorize Old Surety Life Insurance Company to debit / charge my account indicated below.

CHECKING ACCOUNT	SAVINGS ACCOUNT	ACCOUNT #
☐ (Check here for Checking)	☐ (Check here for Savings)	_____ (Enter Account Number here)

BANK NAME

_____

BANK ADDRESS

_____

This authority is to remain in force and effect until the Company has received written notification from me of its termination in such time and in such manner as to afford Company a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notification to Company prior to charging account. The customer has the right to return an item up to 60 days after the charge date if the customer feels that the transaction was not authorized or if the customer is revoking the authorization. In the case of ACH or Electronic Funds Transfer, Old Surety Life Insurance Company indemnifies the receiving financial institution through the National Automated Clearing House Association and local Automated Clearing House Association rules.

SIGNATURE _____

NAME _____
(Print Premium Payor Name)

DATE _____

To: The Bank Named Above:
So that you may comply with your depositor's request this Company agrees:

1. 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 Pre-Authorized Check Plan payment, including any costs or expenses reasonably incurred in connection therewith.
2. 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 any loss even though dishonor results in a forfeiture of the insurance.
3. 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 the foregoing request, or in any manner arising by reason of your participation in the foregoing plan.

Dale L. Phillips
DALE L. PHILLIPS, President

OLD SURETY LIFE INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA
Authorized in a resolution adopted by the Board of Directors of the Old Surety Life Insurance Company, Oklahoma City, Oklahoma on July 27, 1998.

Please attach a voided check here.
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