

SERFF Tracking Number: IASL-126786548 State: Arkansas  
 Filing Company: State Mutual Insurance Company State Tracking Number: 46694  
 Company Tracking Number: MSAPP2010AR  
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010  
 Product Name: SM AR Revised 2010 Application  
 Project Name/Number: SM AR Revised 2010 Application/

## Filing at a Glance

Company: State Mutual Insurance Company

Product Name: SM AR Revised 2010 SERFF Tr Num: IASL-126786548 State: Arkansas

Application

TOI: MS09 Medicare Supplement - Other 2010 SERFF Status: Closed-Approved-Closed State Tr Num: 46694

Sub-TOI: MS09.000 Medicare Supplement Other 2010 Co Tr Num: MSAPP2010AR State Status: Approved-Closed

Filing Type: Form

Author: Beth Clark

Date Submitted: 09/02/2010

Reviewer(s): Stephanie Fowler

Disposition Date: 09/17/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: SM AR Revised 2010 Application

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/17/2010

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: 09/17/2010

Created By: Beth Clark

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Beth Clark

Filing Description:

The submission of this application is intended to replace form MSAPP2010TX that was approved on 05/25/2010, under SERFF # IASL-126598127.

The application was never released and the only change we have made was to Section B. The policy fee was added and we made clarification that the monthly payment mode must be a bank draft.

Insurance Administrative Solutions, LLC has been authorized to submit this filing on behalf of State Mutual Insurance

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Company. Please address any questions/concerns to my attention.

## Company and Contact

### Filing Contact Information

Beth Clark, Compliance Analyst beth.clark@iasadmin.com  
 8545 126th Avenue North 727-584-0007 [Phone] 2169 [Ext]  
 Suite 200 727-584-5613 [FAX]  
 Largo, FL 33773-1502

### Filing Company Information

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

State Mutual Insurance Company	CoCode: 69132	State of Domicile: Georgia
One State Mutual Drive	Group Code: 986	Company Type:
Rome, GA 30165	Group Name:	State ID Number:
(706) 291-1054 ext. [Phone]	FEIN Number: 58-1449898	

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## Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
State Mutual Insurance Company	\$50.00	09/02/2010	39208840

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	09/17/2010	09/17/2010

### 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	09/09/2010	09/09/2010	Beth Clark	09/17/2010	09/17/2010

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Medicare Supplement Application	Beth Clark	09/02/2010	09/02/2010

*SERFF Tracking Number:* IASL-126786548      *State:* Arkansas  
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## **Disposition**

Disposition Date: 09/17/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Letter of Authorization	Accepted for Informational Purposes	Yes
Form ( <i>revised</i> )	Medicare Supplement Application	Approved	Yes
Form	Medicare Supplement Application	Disapproved	Yes
Form	Medicare Supplement Application	Disapproved	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 09/09/2010  
Submitted Date 09/09/2010  
Respond By Date 10/11/2010

Dear Beth Clark,

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)
- Letter of Authorization (Supporting Document)
- Medicare Supplement Application, MSAPP2010AR (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.

### Objection 2

- Flesch Certification (Supporting Document)
- Application (Supporting Document)
- Health - Actuarial Justification (Supporting Document)
- Outline of Coverage (Supporting Document)
- Letter of Authorization (Supporting Document)
- Medicare Supplement Application, MSAPP2010AR (Form)

Comment: R&R 27, Sec. 11.D. requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered." Questions regarding tobacco use should have the same statement unless the question is in the health section.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

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## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 09/17/2010  
 Submitted Date 09/17/2010

Dear Stephanie Fowler,

### Comments:

Good Morning,

### Response 1

Comments: The policy fee has been removed.

### Related Objection 1

Applies To:

- Medicare Supplement Application, MSAPP2010AR (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:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Medicare Supplement Application	MSAPP2010AR		Application/Enrollment Form	Initial			MSAPP2010ARRevised.pdf

### Previous Version

Medicare Supplement Application	MSAPP2010AR		Application/Enrollment Form	Initial			MSAPP2010ARRevised.pdf
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Medicare Supplement Application	MSAPP20 10AR	Application/Enrollment Form	Initial	sed.pdf MSAPP20 10ARRevi sed.pdf
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No Rate/Rule Schedule items changed.

## Response 2

Comments: The tobacco question has been moved to section D. This question will not require an answer if applicant is applying during open enrollment or guarantee issue.

### Related Objection 1

Applies To:

- Medicare Supplement Application, MSAPP2010AR (Form)

Comment:

R&R 27, Sec. 11.D. requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered." Questions regarding tobacco use should have the same statement unless the question is in the health section.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Medicare Supplement Application	MSAPP20 10AR		Application/Enrollment Form	Initial			MSAPP20 10ARRevi sed.pdf

### Previous Version

Medicare Supplement Application	MSAPP20 10AR		Application/Enrollment Form	Initial			MSAPP20 10ARRevi sed.pdf
Medicare Supplement Application	MSAPP20 10AR		Application/Enrollment Form	Initial			MSAPP20 10ARRevi

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sed.pdf

No Rate/Rule Schedule items changed.

Thank you for your time and assistance with this review.

Sincerely,  
Beth Clark

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**Amendment Letter**

Submitted Date: 09/02/2010

**Comments:**

Fixed Agent Writing Number. It was on the wrong line.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
MSAPP2010AR	Application/Enrollment Form	EMedicare Supplement Application	Initial					MSAPP2010ARRRevised.pdf

SERFF Tracking Number: IASL-126786548 State: Arkansas  
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## Form Schedule

**Lead Form Number: MSAPP2010AR**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 09/17/2010	MSAPP2010AR	Application/ Medicare Enrollment Form	Supplement Application	Initial			MSAPP2010ARRevised.pdf



**STATE MUTUAL INSURANCE COMPANY**

[Home Office:Rome, Georgia]  
 [Administration: P.O. Box 10849]  
 [Clearwater, Florida 33757-8849]

**APPLICATION FOR MEDICARE SUPPLEMENT COVERAGE**

<b>SECTION A. PROPOSED INSURED INFORMATION</b>	
Applicant Name <i>(exactly as it appears on your Medicare card)</i>	
Resident Address	Phone <i>(with area code)</i>
City	State, Zip Code
Date of Birth <i>mm/dd/yyyy</i>	Current Age
Male <input type="checkbox"/> Female <input type="checkbox"/>	Social Security No
Medicare Card No	
Email Address	
Height <i>Feet and inches</i>	Weight <i>Pounds</i>

<b>SECTION B. PLAN AND PREMIUM INFORMATION</b>			
Plan	Requested Policy Effective Date		
Premium \$			
Premium Collected \$	Initial Bank Draft: \$	Issue Date <input type="checkbox"/>	Effective Date <input type="checkbox"/>
Payment Mode: Bank Draft	Monthly Bank Draft <input type="checkbox"/> (Bank Draft ONLY)	Annual <input type="checkbox"/>	Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/>

<b>SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS</b>		
1. Are you covered under Medicare Part A?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If YES, what is your Part A effective date?	____ / ____ / ____	
If NO, what is your eligibility date?	____ / ____ / ____	
2. Are you covered under Medicare Part B?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If YES, what is your Part B effective date?	____ / ____ / ____	
If NO, what is your eligibility date?	____ / ____ / ____	
3. Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility).		Yes <input type="checkbox"/> No <input type="checkbox"/>

## SECTION D. HEALTH QUESTIONS

*(You do not have to answer these questions if you are applying during open enrollment or a guaranteed issue period.)*

Have you used tobacco in any form in the past 12 months?

Yes

No

If applying during Open Enrollment or a Guaranteed Issue period, go to SECTION F.

If not, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. If you answer YES to any of the following questions 1 - 14, you are not eligible for coverage.

1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? Yes  No
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? Yes  No
3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis? Yes  No
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder? Yes  No
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes  No
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), or kidney disease? If you do **not** have diabetes, this question should be answered "NO." Yes  No
7. Do you have diabetes that has ever required more than 50 units of insulin daily? Yes  No
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? Yes  No
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? Yes  No
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes  No
11. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts? Yes  No
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes  No
13. Have you been hospital confined three or more times in the last two years? Yes  No
14. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes  No

**SECTION E. MEDICATION HISTORY**

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months?

Yes  No

If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

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Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

**SECTION F. FOR YOUR PROTECTION**, the National Association of Insurance Commissioners require that we ask the following questions about insurance policies or certificates you may have.

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 QUESTIONS.**

To the Best of Your Knowledge:

1. (a) Did you turn age 65 in the last six months? Yes  No   
 (b) Did you enroll in Medicare Part B in the last six months? Yes  No   
 (c) If YES, indicate your effective date. / /

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

3. Have 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.) Yes  No   
 If YES, answer (a) – (g) below.  
 (a) Name of Company \_\_\_\_\_  
 Plan Type & Policy/Certificate No \_\_\_\_\_  
 Company Telephone Number \_\_\_\_\_  
 Coverage Dates: START DATE / /  
 (if you are still covered under this plan, leave end date blank) END DATE / /  
 (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes  No   
 If YES, have you received a copy of the replacement notice? Yes  No   
 (c) Reason for termination/disenrollment? \_\_\_\_\_  
 (d) Planned date of termination/disenrollment? / /  
 (e) Was this your first time in this type of Medicare plan? Yes  No   
 (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes  No   
 (g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes  No

4. Do you have another Medicare supplement or Medicare select insurance policy in force? Yes  No   
 If YES, answer (a) – (d) below.  
 (a) Name of Company \_\_\_\_\_  
 Plan Type & Policy/Certificate No \_\_\_\_\_  
 Company Telephone Number \_\_\_\_\_  
 Issue Date / /  
 (b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? Yes  No   
 (c) Indicate termination date. / /  
 (d) Have you received a copy of the replacement notice? Yes  No

**SECTION F. (continued)**

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) Yes  No

If YES, answer (a) – (c) below.

(a) Name of Company \_\_\_\_\_  
 Plan Type & Policy/Certificate No \_\_\_\_\_  
 Company Telephone Number \_\_\_\_\_  
 Coverage Dates: START DATE / /  
 (if you are still covered under this plan, leave end date blank) END DATE / /  
 (b) Reason for termination/disenrollment? \_\_\_\_\_  
 (c) Planned date of termination/disenrollment? / /

**This section to be completed only by an agent, if applicable.**

Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

(2) List policies sold in the past five (5) years which are no longer in force.

Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

## IMPORTANT STATEMENTS TO BE READ BY APPLICANT

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

**AUTHORIZATION AND CERTIFICATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give State Mutual Insurance Company, or its reinsurers, any such information. I understand that I am authorizing State Mutual Insurance Company to receive my health information and prescription drug usage history. The released information received by State Mutual Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with State Mutual Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to State Mutual Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying State Mutual Insurance Company in writing at their Medicare Supplement Administrative Office: [P.O. Box 10849, Clearwater, Florida 33757-8849.] I understand that such revocation will not have any effect on actions State Mutual Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

**ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at: \_\_\_\_\_  
State                      Applicant's Signature                      Date

This section to be completed only by an agent, if applicable.

Signed at: \_\_\_\_\_  
State                      Agent's Signature and Writing Number                      Date

Policy Mailing Preference:     Mail to Agent     Mail to Applicant

<i>SERFF Tracking Number:</i>	<i>IASL-126786548</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>State Mutual Insurance Company</i>	<i>State Tracking Number:</i>	<i>46694</i>
<i>Company Tracking Number:</i>	<i>MSAPP2010AR</i>		
<i>TOI:</i>	<i>MS09 Medicare Supplement - Other 2010</i>	<i>Sub-TOI:</i>	<i>MS09.000 Medicare Supplement Other 2010</i>
<i>Product Name:</i>	<i>SM AR Revised 2010 Application</i>		
<i>Project Name/Number:</i>	<i>SM AR Revised 2010 Application/</i>		

## Supporting Document Schedules

<b>Satisfied - Item:</b>	Flesch Certification	<b>Item Status:</b>	Accepted for Informational Purposes	<b>Status Date:</b>	09/17/2010
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**Comments:**

The application was scored as part of Plan A.

**Attachment:**

Flesch Cert - IA BOTH.pdf

<b>Bypassed - Item:</b>	Application	<b>Item Status:</b>		<b>Status Date:</b>	
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**Bypass Reason:** This is a new application filing.

**Comments:**

<b>Bypassed - Item:</b>	Health - Actuarial Justification	<b>Item Status:</b>		<b>Status Date:</b>	
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**Bypass Reason:** Not applicable

**Comments:**

<b>Bypassed - Item:</b>	Outline of Coverage	<b>Item Status:</b>		<b>Status Date:</b>	
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**Bypass Reason:** Not applicable

**Comments:**

<b>Satisfied - Item:</b>	Letter of Authorization	<b>Item Status:</b>	Accepted for Informational Purposes	<b>Status Date:</b>	09/17/2010
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**Comments:**

SERFF Tracking Number: IASL-126786548 State: Arkansas  
Filing Company: State Mutual Insurance Company State Tracking Number: 46694  
Company Tracking Number: MSAPP2010AR  
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010  
Product Name: SM AR Revised 2010 Application  
Project Name/Number: SM AR Revised 2010 Application/

**Attachment:**

2010 03 SM IAS Authorization Letter.pdf

# READABILITY COMPLIANCE CERTIFICATION

**Name and Address of Insurer:**

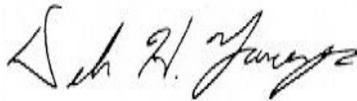
**State Mutual Insurance Company  
One State Mutual Drive  
Rome, Georgia 30161**

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

<b>TYPE/TITLE OF FORM</b>	<b>FORM NUMBERS</b>	<b>FLESCH SCORE</b>
Medicare Supplement Policy – Plan A	MSMSAI2010AR; MSMSDAI2010AR	50.0
Medicare Supplement Policy – Plan B	MSMSBI2010AR; MSMSDBI2010AR	50.1
Medicare Supplement Policy – Plan C	MSMSCI2010AR; MSMSDCI2010AR	50.2
Medicare Supplement Policy – Plan D	MSMSDI2010AR; MSMSDDI2010AR	50.0
Medicare Supplement Policy – Plan F	MSMSFI2010AR; MSMSDFI2010AR	50.2
Medicare Supplement Policy – Plan High F	MSMSRI2010AR; MSMSDRI2010AR	50.7
Medicare Supplement Policy – Plan G	MSMSGI2010AR; MSMSDGI2010AR	50.2
Medicare Supplement Policy – Plan M	MSMSMI2010AR; MSMSDMI2010AR	50.5
Medicare Supplement Policy – Plan N	MSMSNI2010AR; MSMSDNI2010AR	51.1
Medicare Supplement Application	MSAPP2010AR	Scored as a part of the policy.

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

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



President

Date: April 13, 2010



OFFICE: 1-877-872-5500 (TOLL-FREE)  
FAX: 1-727-373-4575

March 5, 2010

Ms. Darcey Shaffer, FLMI, ACS  
Compliance Manager  
Insurance Administrative Solutions, L.L.C.  
8545 126<sup>th</sup> Avenue North, Suite 200  
Largo, Florida 33773-1502

Re: Life and Health Filings for Rate Increases, Forms and Reporting Requirements for  
State Mutual Insurance Company

Dear Ms. Shaffer:

This letter authorizes Insurance Administrative Solutions, L.L.C. to file on behalf of State Mutual Insurance Company, rate increases, forms and reporting requirements for the Company's Life and Health Insurance Policies with the State Insurance Departments. Insurance Administrative Solutions, L.L.C. may correspond with the State Insurance Departments regarding any questions they may have concerning the filings.

A copy of this letter is as valid as the original. This authorization will be valid for twelve months from the date of this letter.

Sincerely,

A handwritten signature in blue ink that reads 'Rick A. Gordon'.

Rick A. Gordon  
Executive Vice President

*SERFF Tracking Number:* IASL-126786548      *State:* Arkansas  
*Filing Company:* State Mutual Insurance Company      *State Tracking Number:* 46694  
*Company Tracking Number:* MSAPP2010AR  
*TOI:* MS09 Medicare Supplement - Other 2010      *Sub-TOI:* MS09.000 Medicare Supplement Other 2010  
*Product Name:* SM AR Revised 2010 Application  
*Project Name/Number:* SM AR Revised 2010 Application/

## 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.

<b>Creation Date:</b>	<b>Schedule</b>	<b>Schedule Item Name</b>	<b>Replacement Creation Date</b>	<b>Attached Document(s)</b>
09/02/2010	Form	Medicare Supplement Application	09/17/2010	MSAPP2010ARRevised.pdf (Superceded)
08/25/2010	Form	Medicare Supplement Application	09/02/2010	MSAPP2010ARRevised.pdf (Superceded)



**STATE MUTUAL INSURANCE COMPANY**

[Home Office:Rome, Georgia]  
 [Administration: P.O. Box 10849]  
 [Clearwater, Florida 33757-8849]

**APPLICATION FOR MEDICARE SUPPLEMENT COVERAGE**

<b>SECTION A. PROPOSED INSURED INFORMATION</b>	
Applicant Name <i>(exactly as it appears on your Medicare card)</i>	
Resident Address	Phone <i>(with area code)</i>
City	State, Zip Code
Date of Birth <i>mm/dd/yyyy</i>	Current Age
Male <input type="checkbox"/> Female <input type="checkbox"/>	Social Security No
Medicare Card No	
Email Address	
Height <i>Feet and inches</i>	Weight <i>Pounds</i>

<b>SECTION B. PLAN AND PREMIUM INFORMATION</b>			
Plan	Requested Policy Effective Date		
Premium \$	Policy Fee \$		
Premium Collected \$	Initial Bank Draft: \$	Issue Date <input type="checkbox"/>	Effective Date <input type="checkbox"/>
Payment Mode: Bank Draft	Monthly Bank Draft <input type="checkbox"/> (Bank Draft ONLY)	Annual <input type="checkbox"/>	Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/>

<b>SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS</b>	
1. Have you used tobacco in any form in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Are you covered under Medicare Part A?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If YES, what is your Part A effective date?      /      /	
If NO, what is your eligibility date?                      /      /	
3. Are you covered under Medicare Part B?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If YES, what is your Part B effective date?      /      /	
If NO, what is your eligibility date?                      /      /	
4. Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility).	Yes <input type="checkbox"/> No <input type="checkbox"/>

## SECTION D. HEALTH QUESTIONS

If applying during Open Enrollment or a Guaranteed Issue period, go to SECTION F.

If not, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. If you answer YES to any of the following questions 1 - 14, you are not eligible for coverage.

1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? Yes  No
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? Yes  No
3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis? Yes  No
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder? Yes  No
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes  No
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), or kidney disease? If you do **not** have diabetes, this question should be answered "NO." Yes  No
7. Do you have diabetes that has ever required more than 50 units of insulin daily? Yes  No
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? Yes  No
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? Yes  No
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes  No
11. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts? Yes  No
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes  No
13. Have you been hospital confined three or more times in the last two years? Yes  No
14. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes  No

**SECTION E. MEDICATION HISTORY**

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months?

Yes  No

If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

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Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

**SECTION F. FOR YOUR PROTECTION**, the National Association of Insurance Commissioners require that we ask the following questions about insurance policies or certificates you may have.

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 QUESTIONS.**

To the Best of Your Knowledge:

1. (a) Did you turn age 65 in the last six months? Yes  No   
 (b) Did you enroll in Medicare Part B in the last six months? Yes  No   
 (c) If YES, indicate your effective date. / /

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

3. Have 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.) Yes  No   
 If YES, answer (a) – (g) below.

(a) Name of Company \_\_\_\_\_

Plan Type & Policy/Certificate No \_\_\_\_\_

Company Telephone Number \_\_\_\_\_

Coverage Dates: START DATE / /

(if you are still covered under this plan, leave end date blank) END DATE / /

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes  No

If YES, have you received a copy of the replacement notice? Yes  No

(c) Reason for termination/disenrollment? \_\_\_\_\_

(d) Planned date of termination/disenrollment? / /

(e) Was this your first time in this type of Medicare plan? Yes  No

(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes  No

(g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes  No

4. Do you have another Medicare supplement or Medicare select insurance policy in force? Yes  No

If YES, answer (a) – (d) below.

(a) Name of Company \_\_\_\_\_

Plan Type & Policy/Certificate No \_\_\_\_\_

Company Telephone Number \_\_\_\_\_

Issue Date / /

- (b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? Yes  No

(c) Indicate termination date. / /

(d) Have you received a copy of the replacement notice? Yes  No

**SECTION F. (continued)**

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) Yes  No

If YES, answer (a) – (c) below.

(a) Name of Company \_\_\_\_\_  
 Plan Type & Policy/Certificate No \_\_\_\_\_  
 Company Telephone Number \_\_\_\_\_  
 Coverage Dates: START DATE / /  
 (if you are still covered under this plan, leave end date blank) END DATE / /  
 (b) Reason for termination/disenrollment? \_\_\_\_\_  
 (c) Planned date of termination/disenrollment? / /

**This section to be completed only by an agent, if applicable.**

Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

(2) List policies sold in the past five (5) years which are no longer in force.

Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

## IMPORTANT STATEMENTS TO BE READ BY APPLICANT

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

**AUTHORIZATION AND CERTIFICATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give State Mutual Insurance Company, or its reinsurers, any such information. I understand that I am authorizing State Mutual Insurance Company to receive my health information and prescription drug usage history. The released information received by State Mutual Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with State Mutual Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to State Mutual Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying State Mutual Insurance Company in writing at their Medicare Supplement Administrative Office: [P.O. Box 10849, Clearwater, Florida 33757-8849.] I understand that such revocation will not have any effect on actions State Mutual Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

**ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at: \_\_\_\_\_  
State                      Applicant's Signature                      Date

This section to be completed only by an agent, if applicable.

Signed at: \_\_\_\_\_  
State                      Agent's Signature and Writing Number                      Date

Policy Mailing Preference:     Mail to Agent     Mail to Applicant



**STATE MUTUAL INSURANCE COMPANY**

[Home Office:Rome, Georgia]  
 [Administration: P.O. Box 10849]  
 [Clearwater, Florida 33757-8849]

**APPLICATION FOR MEDICARE SUPPLEMENT COVERAGE**

<b>SECTION A. PROPOSED INSURED INFORMATION</b>	
Applicant Name <i>(exactly as it appears on your Medicare card)</i>	
Resident Address	Phone <i>(with area code)</i>
City	State, Zip Code
Date of Birth <i>mm/dd/yyyy</i>	Current Age
Male <input type="checkbox"/> Female <input type="checkbox"/>	Social Security No
Medicare Card No	
Email Address	
Height <i>Feet and inches</i>	Weight <i>Pounds</i>

<b>SECTION B. PLAN AND PREMIUM INFORMATION</b>			
Plan	Requested Policy Effective Date		
Premium \$	Policy Fee \$		
Premium Collected \$	Initial Bank Draft: \$	Issue Date <input type="checkbox"/>	Effective Date <input type="checkbox"/>
Payment Mode: Bank Draft	Monthly Bank Draft <input type="checkbox"/> (Bank Draft ONLY)	Annual <input type="checkbox"/>	Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/>

<b>SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS</b>	
1. Have you used tobacco in any form in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Are you covered under Medicare Part A?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If YES, what is your Part A effective date?      /      /	
If NO, what is your eligibility date?                      /      /	
3. Are you covered under Medicare Part B?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If YES, what is your Part B effective date?      /      /	
If NO, what is your eligibility date?                      /      /	
4. Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility).	Yes <input type="checkbox"/> No <input type="checkbox"/>

## SECTION D. HEALTH QUESTIONS

If applying during Open Enrollment or a Guaranteed Issue period, go to SECTION F.

If not, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. If you answer YES to any of the following questions 1 - 14, you are not eligible for coverage.

1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? Yes  No
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? Yes  No
3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis? Yes  No
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder? Yes  No
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes  No
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), or kidney disease? If you do **not** have diabetes, this question should be answered "NO." Yes  No
7. Do you have diabetes that has ever required more than 50 units of insulin daily? Yes  No
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? Yes  No
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? Yes  No
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes  No
11. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts? Yes  No
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes  No
13. Have you been hospital confined three or more times in the last two years? Yes  No
14. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes  No

**SECTION E. MEDICATION HISTORY**

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months?

Yes  No

If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

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Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

**SECTION F. FOR YOUR PROTECTION**, the National Association of Insurance Commissioners require that we ask the following questions about insurance policies or certificates you may have.

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 QUESTIONS.**

To the Best of Your Knowledge:

1. (a) Did you turn age 65 in the last six months? Yes  No   
 (b) Did you enroll in Medicare Part B in the last six months? Yes  No   
 (c) If YES, indicate your effective date. / /

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

3. Have 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.) Yes  No   
 If YES, answer (a) – (g) below.

(a) Name of Company \_\_\_\_\_

Plan Type & Policy/Certificate No \_\_\_\_\_

Company Telephone Number \_\_\_\_\_

Coverage Dates: START DATE / /

(if you are still covered under this plan, leave end date blank) END DATE / /

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes  No

If YES, have you received a copy of the replacement notice? Yes  No

(c) Reason for termination/disenrollment? \_\_\_\_\_

(d) Planned date of termination/disenrollment? / /

(e) Was this your first time in this type of Medicare plan? Yes  No

(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes  No

(g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes  No

4. Do you have another Medicare supplement or Medicare select insurance policy in force? Yes  No

If YES, answer (a) – (d) below.

(a) Name of Company \_\_\_\_\_

Plan Type & Policy/Certificate No \_\_\_\_\_

Company Telephone Number \_\_\_\_\_

Issue Date / /

- (b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? Yes  No

(c) Indicate termination date. / /

(d) Have you received a copy of the replacement notice? Yes  No

**SECTION F. (continued)**

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) Yes  No

If YES, answer (a) – (c) below.

(a) Name of Company \_\_\_\_\_  
 Plan Type & Policy/Certificate No \_\_\_\_\_  
 Company Telephone Number \_\_\_\_\_  
 Coverage Dates: START DATE / /  
 (if you are still covered under this plan, leave end date blank) END DATE / /  
 (b) Reason for termination/disenrollment? \_\_\_\_\_  
 (c) Planned date of termination/disenrollment? / /

**This section to be completed only by an agent, if applicable.**

Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

(2) List policies sold in the past five (5) years which are no longer in force.

Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

## IMPORTANT STATEMENTS TO BE READ BY APPLICANT

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

## AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give State Mutual Insurance Company, or its reinsurers, any such information. I understand that I am authorizing State Mutual Insurance Company to receive my health information and prescription drug usage history. The released information received by State Mutual Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with State Mutual Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to State Mutual Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying State Mutual Insurance Company in writing at their Medicare Supplement Administrative Office: [P.O. Box 10849, Clearwater, Florida 33757-8849.] I understand that such revocation will not have any effect on actions State Mutual Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

**ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at: \_\_\_\_\_  
State                      Applicant's Signature and Writing Number                      Date

This section to be completed only by an agent, if applicable.

Signed at: \_\_\_\_\_  
State                      Agent's Signature                      Date

Policy Mailing Preference:     Mail to Agent     Mail to Applicant