

SERFF Tracking Number: AETN-127745078 State: Arkansas
Filing Company: American Continental Insurance Company State Tracking Number: 50475
Company Tracking Number: TRANSITION 1001
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
Product Name: Medicare supplement
Project Name/Number: Transition Filing/

Filing at a Glance

Company: American Continental Insurance Company

Product Name: Medicare supplement SERFF Tr Num: AETN-127745078 State: Arkansas
TOI: MS09 Medicare Supplement - Other 2010 SERFF Status: Closed-Approved- State Tr Num: 50475
Closed

Sub-TOI: MS09.000 Medicare Supplement Co Tr Num: TRANSITION 1001 State Status: Approved-Closed
Other 2010

Filing Type: Form

Reviewer(s): Stephanie Fowler
Author: Mary Ann Pyle Disposition Date: 12/15/2011
Date Submitted: 12/14/2011 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Transition Filing

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Informational

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 12/15/2011

State Status Changed: 12/15/2011

Deemer Date:

Created By: Mary Ann Pyle

Submitted By: Mary Ann Pyle

Corresponding Filing Tracking Number:

Filing Description:

On October 1, 2011, Aetna acquired American Continental Insurance Company. As a result of that acquisition it was necessary to remove all references to Genworth Financial where it appeared on the enclosed policy forms. The only changes to these forms was the removal of the Genworth Logo which were replaced with the Aetna brand. However, as a result of this change we needed to revise the form numbers in order to distinguish this change.

The forms were previously submitted and approved under SERFF Filing number GEFA- 126424755. The Department filed this on January 27, 2010.

We certify that no other changes have been made to these forms other than removing the Genworth Financial branding

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 and replacing it with the Aetna branding.

If you have any questions regarding this filing please contact Mary Ann Pyle at mary.pyle@aetna.com or 615 312 8852.

Company and Contact

Filing Contact Information

Mary Pyle, SR. COMPLIANCE CONSULTANT Mary.Pyle@Aetna.com
 101 Continental Place 615-312-8852 [Phone]
 Brentwood, TN 37027 615-373-0272 [FAX]

Filing Company Information

American Continental Insurance Company CoCode: 12321 State of Domicile: Tennessee
 101 Continental Place Group Code: Company Type:
 Brentwood, TN 37027 Group Name: State ID Number:
 (615) 370-9044 ext. [Phone] FEIN Number: 20-2901054

Filing Fees

Fee Required? Yes
 Fee Amount: \$300.00
 Retaliatory? No
 Fee Explanation: 6 FORMS X \$50=300
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Continental Insurance Company	\$300.00	12/14/2011	54531547

SERFF Tracking Number: AETN-127745078 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	12/15/2011	12/15/2011

SERFF Tracking Number: *AETN-127745078* *State:* *Arkansas*
Filing Company: *American Continental Insurance Company* *State Tracking Number:* *50475*
Company Tracking Number: *TRANSITION 1001*
TOI: *MS09 Medicare Supplement - Other 2010* *Sub-TOI:* *MS09.000 Medicare Supplement Other 2010*
Product Name: *Medicare supplement*
Project Name/Number: *Transition Filing/*

Disposition

Disposition Date: 12/15/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AETN-127745078 State: Arkansas
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 Product Name: Medicare supplement
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	POLICY COVER	Approved-Closed	Yes
Form	REPLACEMENT FORM	Approved-Closed	Yes
Form	REINSTATEMENT APPLICATION	Approved-Closed	Yes
Form	OUTLINE	Approved-Closed	Yes
Form	HIPAA FORM	Approved-Closed	Yes
Form	APPLICATION	Approved-Closed	Yes

SERFF Tracking Number: AETN-127745078 State: Arkansas
 Filing Company: American Continental Insurance Company State Tracking Number: 50475
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 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
 Product Name: Medicare supplement
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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/15/2011	ACILP01106	Policy Jacket	POLICY COVER	Revised	Replaced Form #: ACIMS001 Previous Filing #: GEFA 126424755		ACILP01106 POLICY COVER MEDSUP ACI.pdf
Approved-Closed 12/15/2011	ACIMS01001	Other	REPLACEMENT FORM	Initial			ACIMS01001 REPLACEMENT MEDSUP.pdf
Approved-Closed 12/15/2011	ACILP01002	Application/Enrollment Form	REINSTATEMENT APPLICATION	Revised	Replaced Form #: ACI0315 Previous Filing #: GEFA 126424755		ACILP01002 REINSTATEMENT APP MEDSUP.pdf
Approved-Closed 12/15/2011	ACIMS01048AR	Outline of Coverage	OUTLINE	Revised	Replaced Form #: ACIMS0358AR Previous Filing #: GEFA 126424755		ACIMS01048 AR-COVER.pdf
Approved-Closed 12/15/2011	ACIMP01003	Other	HIPAA FORM	Revised	Replaced Form #: ACI0322 Previous Filing #: GEFA 126424755		ACIMP01003 HIPAA FORM ACI.pdf
Approved-Closed 12/15/2011	ACIMS01032AR	Application/Enrollment Form	APPLICATION	Revised	Replaced Form #: ACIMS0341AR Previous Filing #: GEFA 126424755		ACIMS01032 AR APPLICATION MEDSUP AR.pdf



MEDICARE SUPPLEMENT INSURANCE POLICY

HELPING PROVIDE FINANCIAL SECURITY

Underwritten by
American Continental Insurance Company

An Aetna Company

*Not connected with or
endorsed by the U.S.
Government or the
Federal Medicare Program*

ACI

WELCOME

Dear Valued Policyholder,

Thank you for your recent application for Medicare Supplement insurance and welcome to our family of policyholders. Enclosed is your policy. We would like for you to take a few minutes to look over the copy of your application in the back of your policy. **It is important that all information including your date of birth, height, weight and health questions are answered correctly.** Please pay close attention to the answers on the health and medical questions as an incorrect answer could jeopardize your coverage under this policy. If you applied during the Open Enrollment or Guarantee Issue period, these health questions will not be answered as they do not apply. If there are any corrections or additions please notify us immediately.

American Continental Insurance Company is committed to providing outstanding service to our policyholders. We feel that our rapid growth is a result of striving for excellence through personalized customer service and products to fulfill your needs. Please take a few moments to review your policy and keep it in a handy place for future reference.

If you have any questions regarding your policy benefits or if we can be of assistance in other ways concerning your insurance needs, please let us hear from you. Our staff of dedicated professionals is ready to assist you.

OUR COMMITMENT

American Continental Insurance Company, headquartered in Brentwood, Tennessee, has an unwavering commitment to providing the best personal service possible, quick claims payment, quality products with solid financial backing, and helpful, friendly associates with extensive knowledge and experience. Policyholders rely on our company to be there when they need us. We take those obligations very seriously and everything we do is focused on fulfilling our commitments in a timely, hassle-free manner – so you have the best experience possible.

American Continental
Insurance Company
An Aetna Company
101 Continental Place
Brentwood, Tennessee 37027
800 264.4000
cont-life.com

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**NOTICE TO APPLICANT REGARDING REPLACEMENT OF
MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE**

American Continental Insurance Company *An Aetna Company*
101 Continental Place, Brentwood, Tennessee 37027

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

According to (your application) (information you have furnished), you intend to terminate existing Medicare Supplement or Medicare Advantage and replace it with a policy to be issued by American Continental Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY PRODUCER: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement 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) (check one):

- Additional benefits
- No change in 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) _____

- (1) 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.
- (2) 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 for similar benefits to the extent such time was spent under the original policy.
- (3) If, you still wish to terminate your present policy or certificate 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 company to deny any future claims and to refund your premium as though your policy or certificate 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.
- (4) Do not cancel your present policy or certificate until you have received your new policy or certificate and are sure that you want to keep it.

Signature of Agent

Signature of Applicant

Printed Name of Agent

Date: _____

Address of Agent

Date: _____

WHITE COPY: Home Office with Completed Application – YELLOW COPY: Applicant



American Continental Insurance Company
 An Aetna Company
 101 Continental Place
 Brentwood, TN 37027

Application for Reinstatement

from American Continental Insurance Company

Page 1 of 2

- Print clearly and use blue or black ink.

1. Insured information

Full name of applicant *First, M.I., Last*

.

Policy number to be reinstated

Telephone number

.

1. Within the past 6 months, have you been medically diagnosed, treated, been prescribed medication for, or had surgery for any illness or injury? Yes No
2. Have you been advised by a medical professional to have tests, surgery, treatment or further evaluation for any illness or injury or are there any tests pending? Yes No
3. Are you taking or have you been advised to take any prescribed medications? Yes No

2. Details of "Yes" Answers

Date Type of injury or illness

.

Fully recovered?

Doctor/Hospital

Medication taken

.

Date Type of injury or illness

.

Fully recovered?

Doctor/Hospital

Medication taken

.

Date Type of injury or illness

.

Fully recovered?

Doctor/Hospital

Medication taken

.

Date Type of injury or illness

.

Fully recovered?

Doctor/Hospital

Medication taken

.

3. Applicant

If this policy is reinstated, such reinstatement shall be in accordance with the terms of the policy and shall not take effect until this application for reinstatement has been approved by the Company. If we reject your Reinstatement Application, we will return the monies you submitted with your Reinstatement Application.

I hereby apply to American Continental Insurance Company for reinstatement of my lapsed policy to be reinstated in reliance on my written answers to the questions on this application. I have read and understand all statements and answers and certify that to the best of my knowledge and belief they are true, complete and correctly recorded. I agree that, if my policy is reinstated, such reinstatement shall be in accordance with the terms of the policy and shall not take effect until this application of reinstatement and the premium payment accompanying this application have been accepted and approved by the Company.

It is further agreed that reinstatement of this policy, if granted by the Company, shall be contestable for fraud or misrepresentation of any material facts stated in, or in connection with, this application for two years after the date of reinstatement.

Signature of applicant

Date

X

City

State

Zip

.

.

.

4. Fraud warnings

Arkansas and Louisiana and Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of the insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine and Tennessee and Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy, is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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

Oklahoma: 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.

Pennsylvania: Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.



101 Continental Place
Brentwood, Tennessee 37027
800 264.4000
cont-life.com

OUTLINE OF COVERAGE

MEDICARE SUPPLEMENT INSURANCE BENEFIT PLANS

Underwritten by
An Aetna Company American Continental Insurance Company

ARKANSAS

AMERICAN CONTINENTAL INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N

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.

Basic Benefits:

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

Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of 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	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	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance			
	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 \$[4660]; paid at 100% after limit reached	Out-of-pocket limit \$[2330]; paid at 100% after limit reached		

*Plans F also has 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 [\$2070] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2070]. 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.

**American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN A**

Zip Codes beginning with 722

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1,490.00	774.80	394.85	124.12	1,656.00	861.12	438.84	137.94

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1,490.00	774.80	394.85	124.12	1,656.00	861.12	438.84	137.94

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1,263.00	656.76	334.70	105.21	1,404.00	730.08	372.06	116.95

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1,192.00	619.84	315.88	99.29	1,325.00	689.00	351.13	110.37

**American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN B**

Zip Codes beginning with 722

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1877.00	976.04	497.41	156.35	2086.00	1084.72	552.79	173.76

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1877.00	976.04	497.41	156.35	2086.00	1084.72	552.79	173.76

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1591.00	827.32	421.62	132.53	1768.00	919.36	468.52	147.27

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1502.00	781.04	398.03	125.12	1669.00	867.88	442.29	139.03

**American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN F**

Zip Codes beginning with 722

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	2125.00	1105.00	563.13	177.01	2361.00	1227.72	625.67	196.67

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	2125.00	1105.00	563.13	177.01	2361.00	1227.72	625.67	196.67

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1801.00	936.52	477.27	150.02	2002.00	1041.04	530.53	166.77

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1700.00	884.00	450.50	141.61	1889.00	982.28	500.59	157.35

**American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN HF**

Zip Codes beginning with 722

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	836.00	434.72	221.54	69.64	928.00	482.56	245.92	77.30

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	836.00	434.72	221.54	69.64	928.00	482.56	245.92	77.30

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	708.00	368.16	187.62	58.98	787.00	409.24	208.56	65.56

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	669.00	347.88	177.29	55.73	743.00	386.36	196.90	61.89

**American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN G**

Zip Codes beginning with 722

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1910.00	993.20	506.15	159.10	2122.00	1103.44	562.33	176.76

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1910.00	993.20	506.15	159.10	2122.00	1103.44	562.33	176.76

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1619.00	841.88	429.04	134.86	1799.00	935.48	476.74	149.86

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1528.00	794.56	404.92	127.28	1698.00	882.96	449.97	141.44

**American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN N**

Zip Codes beginning with 722

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1516.00	788.32	401.74	126.28	1685.00	876.20	446.53	140.36

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1516.00	788.32	401.74	126.28	1685.00	876.20	446.53	140.36

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1285.00	668.20	340.53	107.04	1428.00	742.56	378.42	118.95

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate				Standard Rate			
	Annual	Semi	Qtrly	Mthly	Annual	Semi	Qtrly	Mthly
All	1213.00	630.76	321.45	101.04	1348.00	700.96	357.22	112.29

PREMIUM INFORMATION

American Continental Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the policy will be the renewal premium then in effect for your attained age. Other policies may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age policies.

Premiums payable other than annual will be determined according to the following factors:

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

DISCLOSURES

Use this outline to compare benefits and premium 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 your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to American Continental Insurance Company, P.O. Box 2368, Brentwood, Tennessee 37024. 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 your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do **NOT** cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

The policy may not cover all of your medical costs.

Neither American Continental Insurance Company nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely any 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.

THE FOLLOWING CHARTS DESCRIBE PLANS A, B, F, HIGH DEDUCTIBLE F, G and N OFFERED BY AMERICAN CONTINENTAL INSURANCE COMPANY.

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days 	<p>All but [\$1156]</p> <p>All but [\$289] a day</p> <p>All but [\$578] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>[\$289] a day</p> <p>[\$578] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>[\$1156] (Part A Deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days 21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but [\$144.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to [\$144.50] a day</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

**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.

PLAN A

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

*Once you have been billed [\$140] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First [\$140] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$140] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$140] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$140] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES ●Medically necessary skilled care services and medical supplies ●Durable medical equipment ●First [\$140]of Medicare Approved amounts* ●Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$140] (Part B Deductible) \$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days	All but [\$1156] All but [\$289] a day All but [\$578] a day \$0 \$0	[\$1156] (Part A Deductible) [\$289] a day [\$578] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$144.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$144.50] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

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

* Once you have been billed [\$140] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First [\$140] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$140] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$140] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$140] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES ●Medically necessary skilled care services and medical supplies ●Durable medical equipment ●First [\$140] of Medicare Approved amounts* ●Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$140] (Part B Deductible) \$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but [\$1156]</p> <p>All but [\$289] a day</p> <p>All but [\$578] a day</p> <p>\$0</p> <p>\$0</p>	<p>[\$1156] (Part A Deductible)</p> <p>[\$289] a day</p> <p>[\$578] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but [\$144.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to [\$144.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</p>

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

PLAN F

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

*Once you have been billed [\$140] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First [\$140] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	[\$140] (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next [\$140] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs [\$140] (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES ●Medically necessary skilled care services and medical supplies	100%	\$0	\$0
●Durable medical equipment ●First [\$140] of Medicare Approved amounts*	\$0	[\$140] (Part B Deductible)	\$0
●Remainder of Medicare Approved amounts	80%	20%	\$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

High Deductible F

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

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

***This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2070] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [\$2070]. 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.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2070] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [\$2070] DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days	All but [\$1156] All but [\$289] a day All but [\$578] a day \$0 \$0	[\$1156] (Part A Deductible) [\$289] a day [\$578] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$144.50] a day \$0	\$0 Up to [\$144.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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
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****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed [\$140] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

***This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2070] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [\$2070]. 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.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2070] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [\$2070] DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First [\$140] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	[\$140] (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next [\$140] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs [\$140] (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2070] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [\$2070] DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> ●Medically necessary skilled care services and medical supplies 	100%	\$0	\$0
<ul style="list-style-type: none"> ●Durable medical equipment ●First [\$140] of Medicare Approved amounts* 	\$0	[\$140] (Part B Deductible)	\$0
<ul style="list-style-type: none"> ●Remainder of Medicare Approved amounts 	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2070] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [\$2070] DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days 	<p>All but [\$1156]</p> <p>All but [\$289] a day</p> <p>All but [\$578] a day</p> <p>\$0</p> <p>\$0</p>	<p>[\$1156] (Part A Deductible)</p> <p>[\$289] a day</p> <p>[\$578] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but [\$144.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to [\$144.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

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

PLAN G

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

*Once you have been billed [\$140] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First [\$140] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$140] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next [\$140] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$140] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies •Durable medical equipment •First [\$140] of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$140] (Part B Deductible) \$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days	All but [\$1156] All but [\$289] a day All but [\$578] a day \$0 \$0	[\$1156] (Part A Deductible) [\$289] a day [\$578] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$144.50] a day \$0	\$0 Up to [\$144.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

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

PLAN N

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

*Once you have been billed [\$140] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First [\$140] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts</p>	<p>\$0 Generally 80%</p>	<p>\$0 Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The co-payment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</p>	<p>[\$140] (Part B Deductible) Up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</p>
<p>Part B Excess Charges (Above Medicare-Approved amounts)</p>	<p>\$0</p>	<p>0%</p>	<p>All costs</p>
<p>BLOOD First 3 pints Next [\$140] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts</p>	<p>\$0 \$0 80%</p>	<p>All costs \$0 20%</p>	<p>\$0 [\$140] (Part B Deductible) \$0</p>
<p>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0</p>

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment			
•First [\$140] of Medicare Approved amounts*	\$0	\$0	[\$140] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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



American Continental Insurance Company
 An Aetna Company
 101 Continental Place
 Brentwood, TN 37027

Health Information Authorization

from American Continental Insurance Company

Page 1 of 1

- Print clearly and use blue or black ink.
- This is a HIPAA Compliant Authorization.

To Agent: Have applicant complete and sign home office copy to submit with application.
 Applicant keeps one copy.

Applicant declarations

Please read these statements carefully

I authorize the use and disclosure of health information about me as described herein.

Health Information to be Used or Disclosed: This Authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive; the past, present, or future payment for my health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; alcoholism and mental illness; and may be in electronic or paper form. It does not include information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: American Continental Insurance Company; its insurance support organizations; its affiliates and reinsurers.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: physicians; health professionals; hospitals; clinics; the Veterans Administration; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; consumer reporting agencies; insurance support organizations.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my application; determine premium amounts, adjudicate claims and to support the operations of our health plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization; and that a copy of it is as valid as the original; (2) this Authorization will be valid for 24 months from the date signed; (3) if I do not sign this Authorization, or revoke it by writing to American Continental Insurance Company at its Administrative Office, the Company may decline my application; and (4) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization (5) Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Primary applicant please fill in this information

Signature of applicant	Date	
X	.	

Printed name of applicant		
X		

City	State	Zip
.	.	.

Other important information

Producer Compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.



101 Continental Place
Brentwood, Tennessee 37027
800 264.4000
cont-life.com

APPLICATION

MEDICARE SUPPLEMENT INSURANCE

Underwritten by
An Aetna Company American Continental Insurance Company

Arkansas



American Continental Insurance Company
 An Aetna Company
 101 Continental Place
 Brentwood, TN 37027

Application for Medicare Supplement Insurance

from American Continental Insurance Company

Page 1 of 8

- Print clearly and use blue or black ink.

1. Proposed insured information

Write the name as stated on the Medicare card. Provide a copy of the Medicare card with the application if possible.

Full name of proposed insured *First, M.I., Last*

• _____

Address _____ Phone _____

• _____

City _____ State _____ Zip _____

• _____

E-mail _____ Social Security Number _____

• _____

Write the date of birth that is on the birth certificate.

Birth date *mm/dd/yyyy* _____ Age _____

• _____

Height *Feet and inches* _____ Weight *Pounds* _____ Male

• _____ Female

Are you a legal resident of the United States? Yes No

Have you used any form of tobacco in the past 12 months? Yes No

Include any letters associated with the Medicare number and in the appropriate position. If applicant has not received a Medicare card yet, put "No Medicare number yet".

Medicare card number _____

• _____

Date enrolled in: Medicare Part A _____ Medicare Part B _____

• _____

For Agent Use Only:

Check one if application is for: Open Enrollment Guaranteed Issue

2. Plan and premium information

You have a choice among several payment options or modes for paying your premium (annual, semi-annual, quarterly and monthly electronic funds transfer).

Plan selected: _____

• _____

Requested Medicare Supplement effective date *mm/dd/yyyy* _____

• _____

Annual premium: _____ Payment mode _____

\$ _____ Annually Quarterly

Modal premium: _____ Semi-Annually Monthly EFT (Electronic Funds Transfer)

\$ _____

Policy fee: _____

\$ _____

Total modal premium collected/draft: _____

\$ _____

PAYMENT MODES

Each payment mode, other than annual and monthly electronic funds transfer, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates. The annual and monthly electronic funds transfer modes have the same and lowest total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You may change your payment mode, among the modes available, during the life of your policy.

Application for Medicare Supplement Insurance

Page 3 of 8

Applicant Initials

4. Health questions

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

If the health questions are answered for an Open Enrollment or Guaranteed Issue application, the application cannot be processed and will be returned.

If any health questions are answered "yes" in Section 4, the applicant does not qualify for this insurance with us.

- | | | |
|---|-------------------------|-------------------------|
| 1. Are you dependent on a wheelchair or any motorized mobility device? | <input type="radio"/> Y | <input type="radio"/> N |
| 2. Do any of the following apply to you?
Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy | <input type="radio"/> Y | <input type="radio"/> N |
| 3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?
A. congestive heart failure, unoperated aneurysm, defibrillator | <input type="radio"/> Y | <input type="radio"/> N |
| B. leukemia, lymphoma, multiple myeloma, cirrhosis | <input type="radio"/> Y | <input type="radio"/> N |
| C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy | <input type="radio"/> Y | <input type="radio"/> N |
| D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease | <input type="radio"/> Y | <input type="radio"/> N |
| E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant | <input type="radio"/> Y | <input type="radio"/> N |
| F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV) | <input type="radio"/> Y | <input type="radio"/> N |
| 4. Do you have diabetes?
A. that requires use of insulin | <input type="radio"/> Y | <input type="radio"/> N |
| B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage | <input type="radio"/> Y | <input type="radio"/> N |
| C. with history of heart attack or stroke (at any time) | <input type="radio"/> Y | <input type="radio"/> N |
| D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar | <input type="radio"/> Y | <input type="radio"/> N |
| 5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?
A. alcoholism, drug abuse | <input type="radio"/> Y | <input type="radio"/> N |
| B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder | <input type="radio"/> Y | <input type="radio"/> N |
| C. internal cancer, melanoma, Hodgkin's Disease | <input type="radio"/> Y | <input type="radio"/> N |
| D. hepatitis, disorder of the pancreas | <input type="radio"/> Y | <input type="radio"/> N |
| 6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?
A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease | <input type="radio"/> Y | <input type="radio"/> N |
| B. myasthenia gravis, systemic lupus or connective tissue disorder | <input type="radio"/> Y | <input type="radio"/> N |
| C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living | <input type="radio"/> Y | <input type="radio"/> N |
| D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder | <input type="radio"/> Y | <input type="radio"/> N |
| E. any lung or respiratory disorder and currently use tobacco products | <input type="radio"/> Y | <input type="radio"/> N |
| 7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or any surgery that has not been performed? | <input type="radio"/> Y | <input type="radio"/> N |
| 8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder? | <input type="radio"/> Y | <input type="radio"/> N |

Application for Medicare Supplement Insurance

9. Within the past 12 months, do any of the following apply to you?
- A. had a pacemaker implanted Y N
 - B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer Y N
 - C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer Y N
 - D. had a seizure Y N
10. Was your last blood pressure reading higher than 175 Systolic or higher than 100 Diastolic? Y N

Systolic is the upper number and Diastolic is the bottom number of a blood pressure reading.

5. Health history

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:
.....
.....
2. Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:
.....
.....

3. Prescribed medications	Reason for medications (diagnosis)
.....
.....
.....
.....

Use an additional sheet of paper if needed for explanation.

6. Physician information

Your primary physician	Phone
.....
Physician's office name	
.....	
City	State
.....
Specialist seen in the past 24 months	Specialty
.....
Reason for seeing (diagnosis)	
.....	
Specialist seen in the past 24 months	Specialty
.....
Reason for seeing (diagnosis)	
.....	
Specialist seen in the past 24 months	Specialty
.....
Reason for seeing (diagnosis)	
.....	
Have you seen any additional physicians other than those listed above in the past 24 months?	<input type="radio"/> Y <input type="radio"/> N

7. Important statements

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. 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 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 the suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be 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.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

8. Privacy notice

Although your application is our initial source of information, we may collect information, including health history and medical records, from persons other than you and we may conduct a telephone interview with you. American Continental Insurance Company, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

9. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

Application for Medicare Supplement Insurance

10. Applicant agreement

I hereby apply to American Continental Insurance Company for a policy to be issued in reliance on my written answers to the questions on this application. I have read and understand all statements and answers and certify that to the best of my knowledge and belief, they are true, complete and correctly recorded. I acknowledge that I have received an outline of coverage for the policy applied for and *A Guide to Health Insurance for People with Medicare*.

I agree (1) this application and any policy issued will constitute the entire contract of insurance and the Company will not be bound in any way by any statements, promises or information made or given by or to any agent or other person at any time unless the same is in writing and submitted to the Company at its Home Office and made a part of such contract. Only a Company Officer can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing; and (2) the policy shall not be effective until it has actually been issued by the Company and said policy is manually received and accepted by me and the first premium paid, and there has been no change in my health as stated in the application.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand that if any answers on this application are incorrect, incomplete or untrue, American Continental Insurance Company has the right to adjust my premium, reduce my benefits or rescind the policy.

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

Applicant signature

Date signed

X

.

Application for Medicare Supplement Insurance

11. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Proposed insured's name

•

Account owner name, if different than proposed insured's

•

Account owner relationship to proposed insured:

Business owned

by proposed insured

Living trust

Power of Attorney

Employer

Conservator/guardian

Family member; specify •

Financial institution name

•

Checking

Savings

Routing number

•

Account number

•

This is an example of a personal check. A business check may be different.

For all other checks, use the nine-character bank routing number, which appears between the **1** and **00** symbols, usually at the bottom left corner of the check.

John Henry Doe
PH. 000-000-0000
1234 Any Street
Mycity, TN 00000

Date _____

Pay to the Order of _____ \$ [] Dollars

Local Bank Mycity, TN

ACH RT 012345678

For _____

987654321 1234567 001234

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the **1** symbol at the bottom of the check and usually to the right of the bank routing number.

12. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner

Date

X

•

Application for Medicare Supplement Insurance

13. Agent

All information **must** be completed.

Please list any other medical or health insurance policies sold to the proposed insured.

1) List policies sold which are still in force

-
-

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

-
-

I certify that:

1. I have accurately recorded the information supplied by the applicant.
2. The application was provided to the applicant to review and the applicant has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy.
3. I have provided an outline of coverage for the policy applied for and *A Guide to Health Insurance for People with Medicare* to applicant prior to completing the application.

The writing number reflects where commissions will be paid.

Agent name <i>Printed</i>	Writing number (agent or company)
•	•
Agent signature	State license ID number (for FL only)
X	•
Phone	E-mail
•	•

14. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through American Continental Insurance Company (ACI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACI commission schedule.

Agent Information *Print*

Writing Agent	Percentage
•	• %
Secondary Agent	Writing number
•	•
Writing Agent Signature	Percentage
X	• %

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.



American Continental Insurance Company
 An Aetna Company
 101 Continental Place
 Brentwood, TN 37027

800 264.4000
 cont-life.com
 office hours 7:30 a.m. - 4:30 p.m. CST

Receipt

from American Continental Insurance Company

Page 1 of 1

- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.

Proposed insured's name *Printed* _____ Date of application _____
 . _____ . _____

Initial payment collected (if applicable)
 \$ _____ Check Money order

EFT draft amount
 \$ _____

This acknowledges receipt of your application for an American Continental Insurance Company Medicare Supplement insurance policy.

Agent name *Printed* _____ Phone _____
 . _____ . _____

Signature of agent
X _____

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to American Continental Insurance Company.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

Medicare Supplement Insurance - A. If this payment equals the full, initial premium for the mode of premium payment selected by the applicant; and B. if the answers are true and correct in the application and if American Continental Insurance Company issues a Medicare Supplement policy according to its rules, limits, and standards for the plan and amount applied for by the applicant; then this payment shall be applied to the payment of the first premium of the issued Medicare Supplement policy. No Medicare Supplement policy shall be effective until it has actually been issued by American Continental Insurance Company.

Thank you for choosing American Continental Insurance Company!

SERFF Tracking Number: AETN-127745078 State: Arkansas
 Filing Company: American Continental Insurance Company State Tracking Number: 50475
 Company Tracking Number: TRANSITION 1001
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
 Product Name: Medicare supplement
 Project Name/Number: Transition Filing/

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	12/15/2011
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	12/15/2011
Comments:	PREVIOUSLY FILED AND APPROVED UNDER GEFA 126424755 AND FILED BY THE DEPARTMENT ON JANUARY 27, 2010. SEE COVER LETTER FOR EXPLANATION OF REFILING.		
Attachment:	ACIMS01032AR APPLICATION MEDSUP AR.pdf		

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	12/15/2011
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	12/15/2011
Comments:	N/A		



101 Continental Place
Brentwood, Tennessee 37027
800 264.4000
cont-life.com

APPLICATION

MEDICARE SUPPLEMENT INSURANCE

Underwritten by
An Aetna Company American Continental Insurance Company

Arkansas



American Continental Insurance Company
 An Aetna Company
 101 Continental Place
 Brentwood, TN 37027

Application for Medicare Supplement Insurance

from American Continental Insurance Company

Page 1 of 8

- Print clearly and use blue or black ink.

1. Proposed insured information

Write the name as stated on the Medicare card. Provide a copy of the Medicare card with the application if possible.

Full name of proposed insured *First, M.I., Last*

• _____

Address _____ Phone _____

• _____

City _____ State _____ Zip _____

• _____

E-mail _____ Social Security Number _____

• _____

Write the date of birth that is on the birth certificate.

Birth date *mm/dd/yyyy* _____ Age _____

• _____

Height *Feet and inches* _____ Weight *Pounds* _____ Male

• _____ Female

Are you a legal resident of the United States? Yes No

Have you used any form of tobacco in the past 12 months? Yes No

Include any letters associated with the Medicare number and in the appropriate position. If applicant has not received a Medicare card yet, put "No Medicare number yet".

Medicare card number _____

• _____

Date enrolled in: Medicare Part A _____ Medicare Part B _____

• _____

For Agent Use Only:

Check one if application is for: Open Enrollment Guaranteed Issue

2. Plan and premium information

Plan selected: _____

• _____

Requested Medicare Supplement effective date *mm/dd/yyyy* _____

• _____

You have a choice among several payment options or modes for paying your premium (annual, semi-annual, quarterly and monthly electronic funds transfer).

Annual premium: _____ Payment mode _____

\$ _____ Annually Quarterly

Modal premium: _____ Semi-Annually Monthly EFT (Electronic Funds Transfer)

\$ _____

Policy fee: _____

\$ _____

Total modal premium collected/draft: _____

\$ _____

PAYMENT MODES

Each payment mode, other than annual and monthly electronic funds transfer, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates. The annual and monthly electronic funds transfer modes have the same and lowest total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You may change your payment mode, among the modes available, during the life of your policy.

Application for Medicare Supplement Insurance

Page 3 of 8

Applicant Initials

4. Health questions

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

If the health questions are answered for an Open Enrollment or Guaranteed Issue application, the application cannot be processed and will be returned.

If any health questions are answered "yes" in Section 4, the applicant does not qualify for this insurance with us.

- | | | |
|---|-------------------------|-------------------------|
| 1. Are you dependent on a wheelchair or any motorized mobility device? | <input type="radio"/> Y | <input type="radio"/> N |
| 2. Do any of the following apply to you?
Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy | <input type="radio"/> Y | <input type="radio"/> N |
| 3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?
A. congestive heart failure, unoperated aneurysm, defibrillator | <input type="radio"/> Y | <input type="radio"/> N |
| B. leukemia, lymphoma, multiple myeloma, cirrhosis | <input type="radio"/> Y | <input type="radio"/> N |
| C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy | <input type="radio"/> Y | <input type="radio"/> N |
| D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease | <input type="radio"/> Y | <input type="radio"/> N |
| E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant | <input type="radio"/> Y | <input type="radio"/> N |
| F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV) | <input type="radio"/> Y | <input type="radio"/> N |
| 4. Do you have diabetes?
A. that requires use of insulin | <input type="radio"/> Y | <input type="radio"/> N |
| B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage | <input type="radio"/> Y | <input type="radio"/> N |
| C. with history of heart attack or stroke (at any time) | <input type="radio"/> Y | <input type="radio"/> N |
| D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar | <input type="radio"/> Y | <input type="radio"/> N |
| 5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?
A. alcoholism, drug abuse | <input type="radio"/> Y | <input type="radio"/> N |
| B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder | <input type="radio"/> Y | <input type="radio"/> N |
| C. internal cancer, melanoma, Hodgkin's Disease | <input type="radio"/> Y | <input type="radio"/> N |
| D. hepatitis, disorder of the pancreas | <input type="radio"/> Y | <input type="radio"/> N |
| 6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?
A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease | <input type="radio"/> Y | <input type="radio"/> N |
| B. myasthenia gravis, systemic lupus or connective tissue disorder | <input type="radio"/> Y | <input type="radio"/> N |
| C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living | <input type="radio"/> Y | <input type="radio"/> N |
| D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder | <input type="radio"/> Y | <input type="radio"/> N |
| E. any lung or respiratory disorder and currently use tobacco products | <input type="radio"/> Y | <input type="radio"/> N |
| 7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or any surgery that has not been performed? | <input type="radio"/> Y | <input type="radio"/> N |
| 8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder? | <input type="radio"/> Y | <input type="radio"/> N |

Application for Medicare Supplement Insurance

9. Within the past 12 months, do any of the following apply to you?
- A. had a pacemaker implanted Y N
 - B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer Y N
 - C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer Y N
 - D. had a seizure Y N
10. Was your last blood pressure reading higher than 175 Systolic or higher than 100 Diastolic? Y N

Systolic is the upper number and Diastolic is the bottom number of a blood pressure reading.

5. Health history

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:
.....
.....
2. Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:
.....
.....

3. Prescribed medications	Reason for medications (diagnosis)
.....
.....
.....
.....

Use an additional sheet of paper if needed for explanation.

6. Physician information

Your primary physician Physician's office name City	Phone State
Specialist seen in the past 24 months Reason for seeing (diagnosis)	Specialty
Specialist seen in the past 24 months Reason for seeing (diagnosis)	Specialty
Specialist seen in the past 24 months Reason for seeing (diagnosis)	Specialty

Have you seen any additional physicians other than those listed above in the past 24 months? Y N

7. Important statements

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. 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 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 the suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be 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.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

8. Privacy notice

Although your application is our initial source of information, we may collect information, including health history and medical records, from persons other than you and we may conduct a telephone interview with you. American Continental Insurance Company, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

9. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

Application for Medicare Supplement Insurance

10. Applicant agreement

I hereby apply to American Continental Insurance Company for a policy to be issued in reliance on my written answers to the questions on this application. I have read and understand all statements and answers and certify that to the best of my knowledge and belief, they are true, complete and correctly recorded. I acknowledge that I have received an outline of coverage for the policy applied for and *A Guide to Health Insurance for People with Medicare*.

I agree (1) this application and any policy issued will constitute the entire contract of insurance and the Company will not be bound in any way by any statements, promises or information made or given by or to any agent or other person at any time unless the same is in writing and submitted to the Company at its Home Office and made a part of such contract. Only a Company Officer can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing; and (2) the policy shall not be effective until it has actually been issued by the Company and said policy is manually received and accepted by me and the first premium paid, and there has been no change in my health as stated in the application.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand that if any answers on this application are incorrect, incomplete or untrue, American Continental Insurance Company has the right to adjust my premium, reduce my benefits or rescind the policy.

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

Applicant signature

Date signed

X

.

Application for Medicare Supplement Insurance

11. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Proposed insured's name

•

Account owner name, if different than proposed insured's

•

Account owner relationship to proposed insured:

Business owned

by proposed insured

Living trust

Power of Attorney

Employer

Conservator/guardian

Family member; specify •

Financial institution name

•

Checking

Savings

Routing number

•

Account number

•

This is an example of a personal check. A business check may be different.

For all other checks, use the nine-character bank routing number, which appears between the **11** symbols, usually at the bottom left corner of the check.

John Henry Doe
PH. 000-000-0000
1234 Any Street
Mycity, TN 00000

Date _____

Pay to the Order of _____ \$ [] Dollars

For _____

Local Bank Mycity, TN

ACH RT 012345678

⑆987654321⑆ 123456789 001234

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the **11** symbol at the bottom of the check and usually to the right of the bank routing number.

12. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner

Date

X

•

Application for Medicare Supplement Insurance

13. Agent

All information **must** be completed.

Please list any other medical or health insurance policies sold to the proposed insured.

1) List policies sold which are still in force

-
-

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

-
-

I certify that:

1. I have accurately recorded the information supplied by the applicant.
2. The application was provided to the applicant to review and the applicant has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy.
3. I have provided an outline of coverage for the policy applied for and *A Guide to Health Insurance for People with Medicare* to applicant prior to completing the application.

The writing number reflects where commissions will be paid.

Agent name <i>Printed</i>	Writing number (agent or company)
•	•
Agent signature	State license ID number (for FL only)
X	•
Phone	E-mail
•	•

14. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through American Continental Insurance Company (ACI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACI commission schedule.

Agent Information *Print*

Writing Agent	Percentage
•	• %
Secondary Agent	Writing number
•	•
Writing Agent Signature	Percentage
X	• %

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.



American Continental Insurance Company
 An Aetna Company
 101 Continental Place
 Brentwood, TN 37027

800 264.4000
 cont-life.com
 office hours 7:30 a.m. - 4:30 p.m. CST

Receipt

from American Continental Insurance Company

Page 1 of 1

- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.

Proposed insured's name *Printed* _____ Date of application _____
 . _____ . _____

Initial payment collected (if applicable)
 \$ _____ Check Money order

EFT draft amount
 \$ _____

This acknowledges receipt of your application for an American Continental Insurance Company Medicare Supplement insurance policy.

Agent name *Printed* _____ Phone _____
 . _____ . _____

Signature of agent
X _____

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to American Continental Insurance Company.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

Medicare Supplement Insurance - A. If this payment equals the full, initial premium for the mode of premium payment selected by the applicant; and B. if the answers are true and correct in the application and if American Continental Insurance Company issues a Medicare Supplement policy according to its rules, limits, and standards for the plan and amount applied for by the applicant; then this payment shall be applied to the payment of the first premium of the issued Medicare Supplement policy. No Medicare Supplement policy shall be effective until it has actually been issued by American Continental Insurance Company.

Thank you for choosing American Continental Insurance Company!