

SERFF Tracking Number: MUTM-126989919 State: Arkansas
 Filing Company: Assured Life Association State Tracking Number: 48134
 Company Tracking Number: SOFIA KUEHN
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010
 Standard Plans 2010
 Product Name: Med Supp Transformed App-Assured - T01-2013-03
 Project Name/Number: Med Supp Transformed App-Assured/T01-2013-03

Filing at a Glance

Company: Assured Life Association

Product Name: Med Supp Transformed App-Assured - T01-2013-03 SERFF Tr Num: MUTM-126989919 State: Arkansas

TOI: MS08I Individual Medicare Supplement - Standard Plans 2010 SERFF Status: Closed-Approved-Closed State Tr Num: 48134

Sub-TOI: MS08I.012 Multi-Plan 2010 Co Tr Num: SOFIA KUEHN State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Stephanie Fowler

Disposition Date: 03/09/2011

Authors: Mary Cleasby, Shelly Kaipust, Sofia Kuehn, Jan Serafini, Thea Shepherd, Mary Gregg, Jaime Mosqueda, Gilbert Burket, Krysia Gannon, Ellen Cochrane, Melanie Worth, Robyn Gonzales, Joanne Najdzin, Kristin Miller, Luther Mardock, Neil Sandhoefner, Shirley McPhaull, Katie Tupper

Date Submitted: 03/01/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Med Supp Transformed App-Assured

Status of Filing in Domicile:

Project Number: T01-2013-03

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 03/09/2011

State Status Changed: 03/09/2011

Deemer Date:

Created By: Ellen Cochrane

Submitted By: Ellen Cochrane

Corresponding Filing Tracking Number:

SERFF Tracking Number: MUTM-126989919 State: Arkansas
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Filing Description:

RE: Assured Life Association
NAIC # 56499 FEIN 84-0356870
Individual Medicare Supplement Insurance
Application T01-2013-03

Attached for filing with your department is Application T01-2013-03, which will be used to apply for all of our modernized 2010 Medicare supplement certificates. This application is new and will replace application T01-2008-03, previously approved on July 21, 2009. Application T01-2013-03 will be used by our agency/brokerage distribution channels.

This new application was designed to improve the overall efficiency of our application and underwriting processes. One new optional feature of this application is the applicant's ability to choose to receive electronic Explanation of Benefit statements. We request the use of electronic signature capabilities with this application.

A Memorandum of Variable Material is attached which describes all variable aspects of this application.

The Flesch score for this application is 53.2, when scored with the certificate with which it will be used.

Your consideration and approval of this filing will be most appreciated. If I may be of additional assistance as you complete your review, please do not hesitate to contact me.

Sincerely,

Sofia Kuehn, HIA, ACS, AIRC, AIAA
Phone: 402-351-8498
Fax: 402-351-5298
E-mail: sofia.kuehn@mutualofomaha.com

Company and Contact

Filing Contact Information

Sofia Kuehn - Admin, sofia.kuehn@mutualofomaha.com
Mutual of Omaha 402-351-8498 [Phone]
Mutual of Omaha Plaza 402-351-5298 [FAX]
Omaha, NE 68175

Filing Company Information

Assured Life Association CoCode: 56499 State of Domicile: Colorado

SERFF Tracking Number: MUTM-126989919 State: Arkansas
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 Company Tracking Number: SOFIA KUEHN
 TOI: MS081 Individual Medicare Supplement - Sub-TOI: MS081.012 Multi-Plan 2010
 Standard Plans 2010
 Product Name: Med Supp Transformed App-Assured - T01-2013-03
 Project Name/Number: Med Supp Transformed App-Assured/T01-2013-03
 9777 South Yosemite, Suite 200 Group Code: Company Type: Fraternal Benefit
 Society
 Lone Tree, CO 80124 Group Name: State ID Number:
 (800) 995-5991 ext. [Phone] FEIN Number: 84-0356870

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Assured Life Association	\$50.00	03/01/2011	45153281

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	03/09/2011	03/09/2011

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Disposition

Disposition Date: 03/09/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Memorandum of Variable Material	Approved	Yes
Supporting Document	AR Credit Card Cert	Approved	Yes
Form	Individual Medicare Supplement Insurance Application	Approved	Yes

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Form Schedule

Lead Form Number: T01-2013-03

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 03/09/2011	T01-2013-03	Application/Individual Medicare Enrollment Form	Individual Medicare Supplement Insurance Application	Initial		53.200	T01-2013-03 (AR).pdf

B. Applicant Information (continued)

Applicant A

Applicant B

Go paperless! To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will not receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific EOB. We will continue to mail EOBs if you are entitled to receive any monetary reimbursement from Assured Life Association.

Receive statement online? Y N

Receive statement online? Y N

C. Medicare Information

Please reference your Medicare card to complete this section.

MEDICARE  HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)	
NAME OF BENEFICIARY JANE DOE	
MEDICARE CLAIM NUMBER 000-00-0000-A	SEX FEMALE
IS ENTITLED TO HOSPITAL (PART A)	EFFECTIVE DATE 07-01-2010
MEDICAL (PART B)	

Applicant A

Applicant B

Medicare Claim Number _____	Medicare Claim Number _____
Medicare Part A Effective Date ____ / ____ / ____	Medicare Part A Effective Date ____ / ____ / ____
If you are not covered under Medicare Part A, what is your eligibility date ____ / ____ / ____	If you are not covered under Medicare Part A, what is your eligibility date ____ / ____ / ____
Medicare Part B Effective Date ____ / ____ / ____	Medicare Part B Effective Date ____ / ____ / ____
If you are not covered under Medicare Part B, indicate the date you plan to enroll ____ / ____ / ____	If you are not covered under Medicare Part B, indicate the date you plan to enroll ____ / ____ / ____

T01-2013-03

D. Previous or Existing Coverage Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. **Please include a copy of the notice from your prior insurer with your application.** PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
1. Are you covered for medical assistance through the state Medicaid program?..... (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) If "YES," answer the following about this existing coverage:	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(a) Will Medicaid pay your premiums for this Medicare supplement certificate?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Please answer questions regarding another Medicare supplement or Select plan:		
2. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
If "YES," answer the following about this existing coverage:		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this certificate?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Indicate planned termination or disenrollment date. Applicant A _____ / _____ / _____ Applicant B _____ / _____ / _____		
(c) With what company, and what plan do you have?		

Applicant A	Applicant B
Name of Company	Name of Company
Plan	Plan

Please answer questions regarding Medicare plan coverage (other than Medicare supplement):		
3. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO).....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
If "YES," answer the following about this previous or existing coverage:		
(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. Applicant A START _____ / _____ / _____ END _____ / _____ / _____ Applicant B START _____ / _____ / _____ END _____ / _____ / _____		

<p>(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement certificate?.....</p> <p>(c) Planned date of termination/disenrollment? Applicant A _____ / _____ / _____ Applicant B _____ / _____ / _____</p> <p>(d) Was this your first time in this type of Medicare plan?.....</p> <p>(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....</p> <p>(f) Did you drop a union group or employer health plan to enroll in this Medicare plan?..</p> <p>(g) Please indicate reason for termination/disenrollment:</p> <ul style="list-style-type: none"> ■ Your Medicare Advantage plan is leaving the Medicare program..... ■ Your Medicare Advantage organization stopped offering Medicare Advantage plans..... ■ Your Medicare Advantage organization stopped offering coverage in the area in which you live..... ■ You moved out of the geographic service area of your Medicare Advantage plan..... ■ You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan..... ■ Other: _____ Applicant A _____ Applicant B _____ 	<p>Applicant A</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Check box(s) below if applicable</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p>Applicant B</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
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Please answer questions regarding other health insurance:		
<p>4. Have you had coverage under any other health insurance within the past 63 days?..... (For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)</p> <p>If "YES," answer the following about this previous or existing coverage:</p> <p>(a) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank. Applicant A START _____ / _____ / _____ END _____ / _____ / _____ Applicant B START _____ / _____ / _____ END _____ / _____ / _____</p> <p>(b) Planned date of termination/disenrollment? Applicant A _____ / _____ / _____ Applicant B _____ / _____ / _____</p> <p>(c) With what company and what kind of policy/certificate? (List below.)</p>	<p><input type="checkbox"/> Y <input type="checkbox"/> N</p>	<p><input type="checkbox"/> Y <input type="checkbox"/> N</p>

Applicant A	Applicant B
Name of Company	Name of Company
Policy/Certificate type	Policy/Certificate type

E. Please answer all of the following questions:

<p>To the Best of Your Knowledge and Belief:</p> <p>5. Are you applying during a guaranteed issue period?..... (NOTE: Refer to the guaranteed issue worksheet to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)</p> <p>6. Did you turn age 65 in the last six months?.....</p> <p>7. Did you enroll in Medicare Part B in the last six months?..... If "YES," indicate your effective date. Applicant A _____ / _____ / _____ Applicant B _____ / _____ / _____</p>	<p>Applicant A</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p>	<p>Applicant B</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p>
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IF EITHER YOU OR APPLICANT B ANSWERED "YES" TO QUESTION 5 OR BOTH QUESTIONS 6 AND 7 IN SECTION E, SKIP SECTIONS F & G AND GO TO SECTION H.

T01-2013-03

**If you are applying during an open enrollment or guaranteed issue period:
SKIP SECTIONS F & G and GO TO SECTION H.**

F. Health Information

For all plans, answer questions 8-19.

(If “YES” is answered to any of the following questions 8-18, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
8. Are you currently confined to a wheelchair or any motorized mobility device?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
9. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility where you receive skilled nursing care, or receiving any occupational or physical therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
10. At <u>any time</u> have you been diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Within the past two years have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Cardiomyopathy, Congestive Heart Failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing or any surgery that has not been performed?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
13. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Alzheimer’s Disease, dementia or any other cognitive disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Parkinson’s Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease)?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Systemic Lupus or Myasthenia Gravis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. Chronic hepatitis or cirrhosis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. Osteoporosis with fractures?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
14. Do you have diabetes with complications including retinopathy, neuropathy, peripheral vascular disease, any related heart disorder (Including hypertension/high blood pressure) or kidney disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
15. Do you have an implanted cardiac defibrillator?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
16. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Alcoholism or drug abuse?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Internal cancer, lymphoma or melanoma?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. A stroke or transient ischemic attack (TIA)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?...	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
17. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
18. Have you been hospital confined three or more times in the past two years for a same or similar condition?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
19. Have you used tobacco in any form in the past 12 months?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

T01-2013-03

G. Medication Information

If you are applying OUTSIDE of an open enrollment or guaranteed issue period, please list all over-the-counter or prescription medications you have taken in the past 24 months in the table below.

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

T01-2013-03

H. Agreement and Authorization

IMPORTANT STATEMENTS

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

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO ASSURED LIFE ASSOCIATION

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Assured Life Association and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Assured Life Association. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, Assured Life Association, [P.O. Box 2397, Omaha, NE 68103-2397]. I realize that my right to revoke this authorization is limited to the extent that Assured Life Association has taken action in reliance on the authorization or the law allows Assured Life Association to contest the issuance of the certificate or a claim under the certificate.
- "Personal Information" means all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate certificate and a completed and signed application will become part of each applicant's certificate.

I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. I understand that my certificate benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Assured Life Association.

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** and an Outline of Coverage.

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

 Dated at _____, on _____, _____ Applicant A's Signature
City State Month Day Year

 Dated at _____, on _____, _____ Applicant B's Signature (if applying)
City State Month Day Year

SERFF Tracking Number: MUTM-126989919 State: Arkansas
 Filing Company: Assured Life Association State Tracking Number: 48134
 Company Tracking Number: SOFIA KUEHN
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010
 Standard Plans 2010
 Product Name: Med Supp Transformed App-Assured - T01-2013-03
 Project Name/Number: Med Supp Transformed App-Assured/T01-2013-03

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	03/09/2011
Comments:			
Attachment:			
AR Read Cert.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:			
The Application is attached under the Forms Schedule Tab.			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	Not required for this filing.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	Not required for this filing.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Memorandum of Variable Material	Approved	03/09/2011
Comments:			
Attachment:			
T01-2013-03 MOV (AR).pdf			

SERFF Tracking Number: MUTM-126989919 State: Arkansas
Filing Company: Assured Life Association State Tracking Number: 48134
Company Tracking Number: SOFIA KUEHN
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010
Standard Plans 2010
Product Name: Med Supp Transformed App-Assured - T01-2013-03
Project Name/Number: Med Supp Transformed App-Assured/T01-2013-03

Satisfied - Item: AR Credit Card Cert **Item Status:** Approved **Status Date:** 03/09/2011
Comments:
Attachment:
AR Credit Card Cert.pdf

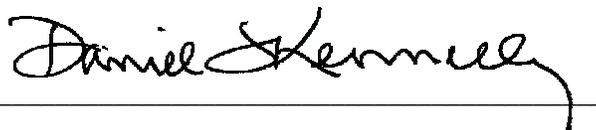
CERTIFICATION

This is to certify that the attached form(s) has/have achieved the following Flesch Reading Ease Score(s) and complies/comply with the requirements of Ark. Stat. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form</u>	<u>Description</u>	<u>Score</u>
T01-2013-03	Individual Medicare Supplement Insurance Application	53.2*

*This score was achieved by removing language or terminology entitled to be excepted by your state's readability regulation.

Date: March 1, 2011



Daniel J. Kennelly
Vice President, Chief Compliance and Ethics Officer
Mutual of Omaha Insurance Company
as Administrator for
Assured Life Association

**Memorandum of Variability
Explanation of Variable Statements and Fields
For Assured Life Association
Application Form T01-2013-03**

Each variable section, statement or field is denoted by [brackets] and annotated with numbers in **RED**. The explanations below follow the order in which the variable fields appear in the form. Address/PO Box should be considered variable to accommodate an address change, in which case the department will be notified.

<i>Variable Statements/Fields</i>	<i>How or When Used</i>
1. [Agent Writing #]	Will display or remove these administrative fields on the applications based on distribution type.
2. [<u>A. Plan Information (to be completed by Producer)....</u>] 2a. [Deliver Certificate To Delivery Method Applicant A <input type="checkbox"/> Producer <input type="checkbox"/> Mail <input type="checkbox"/> E-mail <input type="checkbox"/>]	2. Section will display on applications used by our Agency and Brokerage distributions, and will be removed for our Direct-to-Consumer distributions. The Medicare supplement plans available will be displayed. 2a. Will display or be removed on the application. E-mail delivery will be displayed or removed in this section based on the availability to provide an email certificate delivery service.
3. [Go paperless! To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B....]	Will display or be removed on the application based on the availability of this service.

Arkansas Insurance Department

Mike Huckabee
Governor



Julie Benafield Bowman
Commissioner

Please read and acknowledge your understanding and assurance of complying with the following requirements:

1. If a sponsor or endorser is involved such as a bank, school, retail store, etc., it must be ascertained whether that sponsor is to receive any form of compensation for the use of the card. If so, this must be disclosed to the insured. If there is compensation, the sponsor would need to be licensed to sell insurance.
2. The company must certify that failure to pay the credit card bill will not affect the premium payment.
3. If the credit card company does not pay the premium for any reason, the insurance company must notify the insured of this and allow a thirty day Grace Period for the insured to pay the premium.



March 1, 2011

SIGNATURE

DATE

VP, Chief Compliance & Ethics Officer, Mutual of Omaha Ins Co
as Administrator for Assured Life Association

COMPANY

CC-1