

SERFF Tracking Number: PHYS-127065677 State: Arkansas
Filing Company: Physicians Life Insurance Company State Tracking Number: 48458
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life, Medicare Supplement, Dental Combo Application
Project Name/Number: /

Filing at a Glance

Company: Physicians Life Insurance Company

Product Name: Life, Medicare Supplement, Dental Combo Application SERFF Tr Num: PHYS-127065677 State: Arkansas

TOI: L08 Life - Other SERFF Status: Closed-Approved- Closed State Tr Num: 48458

Sub-TOI: L08.000 Life - Other Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Linda Bird

Author: Sonja Morton Disposition Date: 04/14/2011
Date Submitted: 04/11/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name: Status of Filing in Domicile: Authorized
Project Number: Date Approved in Domicile: 03/07/2011
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: 04/14/2011
State Status Changed: 04/14/2011
Deemer Date: Created By: Sonja Morton
Submitted By: Sonja Morton Corresponding Filing Tracking Number:
Filing Description:
RE: Physicians Life Insurance Company – NAIC 72125 - Group 367, FEIN 47-0529583
Individual Life Insurance
M-NB-MSA001-AR-T – Medicare Supplement Application/Dental Enrollment/Life Application & Variables

The captioned form is submitted for your review and approval. The form is new and does not replace any forms previously approved by your Department. To the best of my knowledge, this form complies with all state laws and regulations.

The M-NB-MSA001-AR-T is a combination of a Medicare Supplement Application, Dental Enrollment and Life

SERFF Tracking Number: *PHYS-127065677* State: *Arkansas*
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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: The filing fee is %50.00 per form. We are filing one form, so the filing fee is \$50.00.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Physicians Life Insurance Company	\$50.00	04/11/2011	46449850

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/14/2011	04/14/2011

SERFF Tracking Number: *PHYS-127065677* State: *Arkansas*
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Disposition

Disposition Date: 04/14/2011

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		Yes
Supporting Document	Application		Yes
Supporting Document	M-NB-MSA001-AR-T Statement of Variability		Yes
Form	Medicare Supplement Application/Dental Enrollment/Life Application		Yes

SERFF Tracking Number: *PHYS-127065677* State: *Arkansas*
 Filing Company: *Physicians Life Insurance Company* State Tracking Number: *48458*
 Company Tracking Number:
 TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*
 Product Name: *Life, Medicare Supplement, Dental Combo Application*
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Form Schedule

Lead Form Number: M-NB-MSA001-AR-T

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	M-NB-MSA001-AR-T	Application/ Medicare Enrollment Form	Supplement Application/Dental Enrollment/Life Application	Initial		40.000	M-NB-MSA001-AR-T.pdf

Application for Medicare Supplement [Optional Dental Enrollment] **(a)** [Optional Life Insurance Application] **(b)**

Plan Selection

Please **initial** the following coverage(s) for which you are applying:

_____	Medicare Supplement Insurance Underwritten by Physicians Mutual Insurance Company Complete the Medicare Supplement Plan Information and Questions Sections	
[_____]	Dental Insurance Underwritten by Physicians Mutual Insurance Company Complete the Optional Dental Plan Information Section	(c)
[_____]	Life Insurance Underwritten by Physicians Life Insurance Company Complete the Optional Life Insurance Application Section	(d)

Personal Information (please print)

Applicant's Name _____		Date of Birth _____ / _____ / _____		Age _____
First	Middle Initial	Last	Month	Day
Address _____		Apartment Number _____		<input type="checkbox"/> Female <input type="checkbox"/> Male
Street				
City	State	Zip Code _____		
Phone Number (____) _____	Social Security Number _____ - _____ - _____			
Date of Application _____ / _____ / _____	Email Address _____			
Month	Day	Year		

Medicare Supplement Plan Information

Requested Effective Date _____ / _____ / _____	Month	Day	Year
Applicant's Medicare Health Insurance Claim Number (HICN) (exactly as shown on your Medicare card)			

Plan Selection (check one) <input type="checkbox"/> Plan A/P020 <input type="checkbox"/> Plan F/P025 <input type="checkbox"/> High Deductible Plan F/P027 <input type="checkbox"/> Plan G/P026 <input type="checkbox"/> Plan N/P029	Rate Structure (check one) <input type="checkbox"/> Community Rating (10) <input type="checkbox"/> Community Rating (20)
<input type="checkbox"/> Plan F/P025 With Innovative Discount Rider/B345	<input type="checkbox"/> Community Rating (20)

Payment Options: [<input type="checkbox"/> ABW (monthly) Type 1 <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semiannual <input type="checkbox"/> Annual] (g) [Modal Premium Selected \$ _____ Monthly Premium \$ _____] (h)

Medicare Supplement Questions

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

To the best of your knowledge:

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 1. Are you covered under Medicare Part A? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what is your Part A effective date? _____ | | |
| Month / Day / Year | | |
| If no, what is your eligibility date? _____ | | |
| Month / Day / Year | | |
| 2. Are you covered under Medicare Part B? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what is your Part B effective date? _____ | | |
| Month / Day / Year | | |
| If no, what date do you plan to enroll? _____ | | |
| Month / Day / Year | | |
| 3. Did you turn age 65 in the last six months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3a. Will you turn age 65 in the next six months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3b. Did you enroll in Medicare Part B in the last six months? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what is your effective date? _____ | | |
| Month / Day / Year | | |
| If you answered "YES" to any portion of question 3, you do not need to answer questions 8 – 24. | | |
| 4. Are you covered for medical assistance through the state Medicaid program? | <input type="checkbox"/> | <input type="checkbox"/> |
| NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. | | |
| If yes: | | |
| a. Will Medicaid pay your premiums for this Medicare Supplement policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 5. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. | | |
| Start Date _____ End Date _____ | | |
| Month / Day / Year Month / Day / Year | | |
| a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please show requested date of termination/disenrollment _____ | | |
| Month / Day / Year | | |
| b. Was this your first time in this type of Medicare plan? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 6. Do you have another Medicare Supplement policy in force? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. If so, with what company and what plan do you have? _____ | | |
| b. If so, do you intend to replace your current Medicare Supplement policy with this policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, enter requested date of termination/disenrollment _____ | | |
| Month / Day / Year | | |

<p>7. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan).....</p> <p>a. If so, with what company and what kind of policy? _____</p> <p>b. What are your dates of coverage under the other policy? (If you are still covered under this plan, leave "END" blank) Start Date _____ / _____ / _____ End Date _____ / _____ / _____ <small style="margin-left: 100px;">Month Day Year</small> <small style="margin-left: 100px;">Month Day Year</small></p> <p>c. If you are still covered by the policy described above, do you intend to replace your current coverage with this new Medicare Supplement policy?</p> <p style="margin-left: 20px;">If yes, please show requested date of termination/disenrollment. _____ / _____ / _____ <small style="margin-left: 100px;">Month Day Year</small></p>	<p><u>YES NO</u></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>
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<p>8. Please provide your height _____ (ft./in.) and weight _____ (lbs.)</p>
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<p>9. Have you used tobacco products in the past 12 months?</p>	<p><u>YES NO</u></p> <p><input type="checkbox"/> <input type="checkbox"/></p>
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<p>Answer questions 10 and 11 only if you will be 68 years of age or younger on the effective date of the coverage for which you are applying. Otherwise, go to question 12.</p>		<p><u>YES NO</u></p>
<p>10. Do any of these apply to you:</p> <ul style="list-style-type: none"> • Have end stage renal (kidney) disease..... • Currently receiving dialysis • Diagnosed with kidney disease that may require dialysis • Diagnosed with or treated for internal cancer or melanoma within the past two years • Admitted to the hospital as an inpatient within the past three months • Have insulin dependent diabetes..... • Use oxygen as a treatment for a diagnosed medical condition..... <p>11. Within the past two years, has a medical professional recommended or discussed as a treatment option, any of the following that has NOT been completed:</p> <ul style="list-style-type: none"> • Hospital admittance as an inpatient..... • Any surgery (including cataract surgery) • Use of oxygen..... <p>Note: If you answered "YES" to any item in question 10 or 11, you will not qualify for coverage.</p>	<p><input type="checkbox"/> <input type="checkbox"/></p>	

<p>Answer questions 12 – 24 only if you will be over 68 years of age on the effective date of the coverage for which you are applying. Otherwise, skip questions 12 – 24.</p>		<p><u>YES NO</u></p>
<p>12. Have you been hospitalized or confined to a nursing home within the past 90 days, or have you been hospitalized two or more times in the past 12 months?</p> <p>13. Do you require the use of a walker?</p> <p>14. Are you bedridden, or do you require the use of a wheelchair?</p> <p>15. Do you have or have you been told by a medical professional that you have Alzheimer's Disease, Dementia, or any other cognitive disorder?.....</p> <p>16. Have you been diagnosed as having, or received treatment by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), and/or Positive HIV and/or AIDS Related Complex (ARC)?</p> <p>17. Are you taking prescription drugs for both diabetes and a heart condition (including high blood pressure)?</p> <p>18. Are you taking anti-coagulant (blood thinner) drugs?.....</p>	<p><input type="checkbox"/> <input type="checkbox"/></p>	

19. Have you been advised by a medical professional that you may need surgery or a non-routine medical procedure within the next 12 months? (includes cataract surgery)	<u>YES</u> <u>NO</u> <input type="checkbox"/> <input type="checkbox"/>
20. Within the past two years have you been diagnosed with, told by a medical professional that you have, or have you been treated for any of the following:	
• alcoholism; drug addiction (or drug abuse)	<input type="checkbox"/> <input type="checkbox"/>
• internal cancer; leukemia; malignant melanoma;	<input type="checkbox"/> <input type="checkbox"/>
• congestive heart failure; valvular heart disease; coronary artery disease; heart rhythm disorder, heart attack; heart surgery (includes bypass, balloon surgery, or placement of an arterial stent);	<input type="checkbox"/> <input type="checkbox"/>
• insulin dependent diabetes;	<input type="checkbox"/> <input type="checkbox"/>
• systemic lupus erythematosus (SLE);	<input type="checkbox"/> <input type="checkbox"/>
• multiple sclerosis; Amyotrophic Lateral Sclerosis (ALS); Parkinson's Disease;	<input type="checkbox"/> <input type="checkbox"/>
• fractures or amputation caused by disease; degenerative bone disease; severe arthritis involving major joints (hip, knee or shoulder) or the spine;	<input type="checkbox"/> <input type="checkbox"/>
• liver disease; chronic kidney disorder; kidney failure; kidney dialysis;	<input type="checkbox"/> <input type="checkbox"/>
• chronic obstructive pulmonary disease (COPD) or emphysema;	<input type="checkbox"/> <input type="checkbox"/>
• an illness or condition for which you use oxygen;	<input type="checkbox"/> <input type="checkbox"/>
• stroke; transient ischemic attack (TIA);	<input type="checkbox"/> <input type="checkbox"/>
Note: If you answered "YES" to any of questions 12-20, you will not qualify for coverage.	
21. Do you have a Chronic Lung Disease, Chronic Bronchitis, or Breathing Disorder?	<input type="checkbox"/> <input type="checkbox"/>
22. In the past 12 months have you received medical treatment in an assisted living facility?	<input type="checkbox"/> <input type="checkbox"/>
If yes, please explain. _____ _____	
23. Do you have a mental disease or disorder requiring medication (including depression)?	<input type="checkbox"/> <input type="checkbox"/>

24. In the past 12 months, have you taken or been advised to take any prescription drugs, over the counter drugs, or medicines including narcotics, barbiturates or amphetamines?

If "YES," indicate the specifics below:

Medication Name	Quantity Taken	Dosage	Prescribing Physician	Illness for Which Medication Prescribed	Date Last Prescribed

Important Statements to be Read by Medicare Supplement Applicant

- (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).

Optional Dental Plan Enrollment (Not required for issue of Medicare Supplement)

Dental Certificate C250 issued to the Delaware Group Insurance Trust

Plan Selection (check one) [Applicant Only Applicant/Spouse] ⁽ⁱ⁾

Spouse Information (only if Applicant/Spouse dental coverage is selected):

Spouse's Name

First

Middle Initial

Last

^(m)

Date of Birth

____ / ____ / ____
Month Day Year

Age

Male

Female

^(k)

Choose your level of benefits: Schedule: [A D E] ⁽ⁿ⁾

Requested Effective Date

____ / ____ / ____
Month Day Year

Payment Options: [ABW (monthly) Monthly Quarterly Semiannual Annual] ^(o)

[Modal Premium Selected \$

Monthly Premium \$

] ^(p)

Optional Life Insurance Application (Not required for issue of Medicare Supplement)

Life Policy [L728, Modified Whole Life Insurance] (r) Underwritten by Physicians Life Insurance Company

Face Amount:

[\$5,000 \$6,000 \$7,000 \$8,000 \$9,000 \$10,000] (s)

Optional Accidental Death Benefit (Rider LR-49):

[\$5,000 \$6,000 \$7,000 \$8,000 \$9,000 \$10,000] (t)

Beneficiary's Name

First Middle Initial Last

Relationship to Insured (u)

Contingent Beneficiary's Name

First Middle Initial Last

Relationship to Insured (q)

Do you have any existing life insurance or annuities? Yes No

[If yes, the Replacement of Life Insurance or Annuities form must be completed.] (v)

In the event of nonpayment of premiums, do you wish to use part of your cash value (if any) as a loan to pay the past due amount to keep your coverage in force? Yes No (w)

[Requested Effective Date / /] (x)
Month Day Year

Payment Options: [ABW (monthly) Monthly Quarterly Semiannual Annual] (y)

[Modal Premium Selected \$ Monthly Premium \$] (z)

This statement applies only to the Medicare Supplement application: The Undersigned applicant and insurance producer certify that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the Medicare Supplement policy.

I represent and agree that all information stated in this application is complete and correct to the best of my knowledge.

This statement applies only to applicants enrolling for optional Dental Certificate C250: I am enrolling for Certificate C250 and the plan selected issued to the Delaware Group Insurance Trust. I understand no coverage is in force until the Company issues a certificate showing a Certificate Effective Date and the first full premium has been paid. This Product is being purchased separately from the Medicare Supplement product. Benefits are not inclusive to the Medicare Supplement product. This product may be purchased without purchasing the Medicare Supplement product. (aa)

This statement applies only to applicants for optional Life Insurance Policy L728: I understand that the Life Insurance coverage I am applying for will not be in force until my application has been received by Physicians Life Insurance Company and my first premium has been paid during my lifetime. I also understand that a reduced death benefit amount is payable during the first two years. This Product is being purchased separately from the Medicare Supplement product. Benefits are not inclusive to the Medicare Supplement product. This product may be purchased without purchasing the Medicare Supplement product. (bb)

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

X
Applicant's Signature

Date Application Completed / /
Month Day Year

Dated at City State

I represent and agree that I have truly and accurately recorded in this application all information supplied by the applicant and personally witnessed (his-her) signature. I also certify that only Company approved sales material was used in connection with this sale [, and copies of all Life sales materials used were left with the applicant, if the existing Life policy is being replaced]. (dd)

This Medicare Supplement policy does replace does not replace any insurance presently in force.

[This Life Insurance policy (if applied for) does replace does not replace any insurance presently in force.] (cc)

X

Licensed Resident Insurance Producer's Signature

X

Licensed Resident Insurance Producer's Signature

Licensed Resident Insurance Producer's Printed Name

Licensed Resident Insurance Producer's Printed Name

Licensed Resident Insurance Producer's NPN

Licensed Resident Insurance Producer's NPN

To Be Filled Out By Insurance Producer

1. List any other health insurance policies you have sold the applicant which are still in force:

2. List any other health insurance policies you have sold the applicant in the past five (5) years which are no longer in force:

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: READCERT AR - PLIC.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application Comments: Attachment: M-NB-MSA001-AR-T.pdf		

	Item Status:	Status Date:
Satisfied - Item: M-NB-MSA001-AR-T Statement of Variability Comments: Attachment: Statement of Variability for AR.pdf		

**PHYSICIANS LIFE INSURANCE COMPANY
OMAHA, NEBRASKA
Certification of Flesch**

These form(s) have the following Flesch Readability Score:

<u>Form</u>	<u>Flesch Score</u>
M-NB-MSA001-AR-T	40*

*When scored with the base policy, the Flesch score will always be the minimum required by statute.



Vice President
Physicians Life Insurance Company

March 25, 2011
Date

Medicare Supplement Questions

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

To the best of your knowledge:

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 1. Are you covered under Medicare Part A? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what is your Part A effective date? _____ | | |
| Month / Day / Year | | |
| If no, what is your eligibility date? _____ | | |
| Month / Day / Year | | |
| 2. Are you covered under Medicare Part B? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what is your Part B effective date? _____ | | |
| Month / Day / Year | | |
| If no, what date do you plan to enroll? _____ | | |
| Month / Day / Year | | |
| 3. Did you turn age 65 in the last six months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3a. Will you turn age 65 in the next six months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3b. Did you enroll in Medicare Part B in the last six months? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what is your effective date? _____ | | |
| Month / Day / Year | | |
| If you answered "YES" to any portion of question 3, you do not need to answer questions 8 – 24. | | |
| 4. Are you covered for medical assistance through the state Medicaid program? | <input type="checkbox"/> | <input type="checkbox"/> |
| NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. | | |
| If yes: | | |
| a. Will Medicaid pay your premiums for this Medicare Supplement policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 5. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. | | |
| Start Date _____ End Date _____ | | |
| Month / Day / Year Month / Day / Year | | |
| a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please show requested date of termination/disenrollment _____ | | |
| Month / Day / Year | | |
| b. Was this your first time in this type of Medicare plan? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 6. Do you have another Medicare Supplement policy in force? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. If so, with what company and what plan do you have? _____ | | |
| b. If so, do you intend to replace your current Medicare Supplement policy with this policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, enter requested date of termination/disenrollment _____ | | |
| Month / Day / Year | | |

<p>7. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan).....</p> <p>a. If so, with what company and what kind of policy? _____</p> <p>b. What are your dates of coverage under the other policy? (If you are still covered under this plan, leave "END" blank) Start Date _____ / _____ / _____ End Date _____ / _____ / _____ <small>Month Day Year Month Day Year</small></p> <p>c. If you are still covered by the policy described above, do you intend to replace your current coverage with this new Medicare Supplement policy?</p> <p style="margin-left: 20px;">If yes, please show requested date of termination/disenrollment. _____ / _____ / _____ <small>Month Day Year</small></p>	<p><u>YES NO</u></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>
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<p>8. Please provide your height _____ (ft./in.) and weight _____ (lbs.)</p>
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<p>9. Have you used tobacco products in the past 12 months?</p>	<p><u>YES NO</u></p> <p><input type="checkbox"/> <input type="checkbox"/></p>
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<p>Answer questions 10 and 11 only if you will be 68 years of age or younger on the effective date of the coverage for which you are applying. Otherwise, go to question 12.</p>		<p><u>YES NO</u></p>
<p>10. Do any of these apply to you:</p> <ul style="list-style-type: none"> • Have end stage renal (kidney) disease..... • Currently receiving dialysis • Diagnosed with kidney disease that may require dialysis • Diagnosed with or treated for internal cancer or melanoma within the past two years • Admitted to the hospital as an inpatient within the past three months • Have insulin dependent diabetes..... • Use oxygen as a treatment for a diagnosed medical condition..... <p>11. Within the past two years, has a medical professional recommended or discussed as a treatment option, any of the following that has NOT been completed:</p> <ul style="list-style-type: none"> • Hospital admittance as an inpatient..... • Any surgery (including cataract surgery) • Use of oxygen..... <p>Note: If you answered "YES" to any item in question 10 or 11, you will not qualify for coverage.</p>	<p><input type="checkbox"/> <input type="checkbox"/></p>	

<p>Answer questions 12 – 24 only if you will be over 68 years of age on the effective date of the coverage for which you are applying. Otherwise, skip questions 12 – 24.</p>		<p><u>YES NO</u></p>
<p>12. Have you been hospitalized or confined to a nursing home within the past 90 days, or have you been hospitalized two or more times in the past 12 months?</p> <p>13. Do you require the use of a walker?</p> <p>14. Are you bedridden, or do you require the use of a wheelchair?</p> <p>15. Do you have or have you been told by a medical professional that you have Alzheimer's Disease, Dementia, or any other cognitive disorder?.....</p> <p>16. Have you been diagnosed as having, or received treatment by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), and/or Positive HIV and/or AIDS Related Complex (ARC)?</p> <p>17. Are you taking prescription drugs for both diabetes and a heart condition (including high blood pressure)?</p> <p>18. Are you taking anti-coagulant (blood thinner) drugs?.....</p>	<p><input type="checkbox"/> <input type="checkbox"/></p>	

	<u>YES</u>	<u>NO</u>
19. Have you been advised by a medical professional that you may need surgery or a non-routine medical procedure within the next 12 months? (includes cataract surgery)	<input type="checkbox"/>	<input type="checkbox"/>
20. Within the past two years have you been diagnosed with, told by a medical professional that you have, or have you been treated for any of the following:		
• alcoholism; drug addiction (or drug abuse)	<input type="checkbox"/>	<input type="checkbox"/>
• internal cancer; leukemia; malignant melanoma;	<input type="checkbox"/>	<input type="checkbox"/>
• congestive heart failure; valvular heart disease; coronary artery disease; heart rhythm disorder, heart attack; heart surgery (includes bypass, balloon surgery, or placement of an arterial stent);	<input type="checkbox"/>	<input type="checkbox"/>
• insulin dependent diabetes;	<input type="checkbox"/>	<input type="checkbox"/>
• systemic lupus erythematosus (SLE);	<input type="checkbox"/>	<input type="checkbox"/>
• multiple sclerosis; Amyotrophic Lateral Sclerosis (ALS); Parkinson's Disease;	<input type="checkbox"/>	<input type="checkbox"/>
• fractures or amputation caused by disease; degenerative bone disease; severe arthritis involving major joints (hip, knee or shoulder) or the spine;	<input type="checkbox"/>	<input type="checkbox"/>
• liver disease; chronic kidney disorder; kidney failure; kidney dialysis;	<input type="checkbox"/>	<input type="checkbox"/>
• chronic obstructive pulmonary disease (COPD) or emphysema;	<input type="checkbox"/>	<input type="checkbox"/>
• an illness or condition for which you use oxygen;	<input type="checkbox"/>	<input type="checkbox"/>
• stroke; transient ischemic attack (TIA);	<input type="checkbox"/>	<input type="checkbox"/>
Note: If you answered "YES" to any of questions 12-20, you will not qualify for coverage.		
21. Do you have a Chronic Lung Disease, Chronic Bronchitis, or Breathing Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
22. In the past 12 months have you received medical treatment in an assisted living facility?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain. _____		

23. Do you have a mental disease or disorder requiring medication (including depression)?	<input type="checkbox"/>	<input type="checkbox"/>

24. In the past 12 months, have you taken or been advised to take any prescription drugs, over the counter drugs, or medicines including narcotics, barbiturates or amphetamines?

If "YES," indicate the specifics below:

Medication Name	Quantity Taken	Dosage	Prescribing Physician	Illness for Which Medication Prescribed	Date Last Prescribed

Important Statements to be Read by Medicare Supplement Applicant

- (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).

Optional Dental Plan Enrollment (Not required for issue of Medicare Supplement)

Dental Certificate C250 issued to the Delaware Group Insurance Trust

Plan Selection (check one) [Applicant Only Applicant/Spouse] ⁽ⁱ⁾

Spouse Information (only if Applicant/Spouse dental coverage is selected):

Spouse's Name

First

Middle Initial

Last

^(m)

Date of Birth

____ / ____ / ____
Month Day Year

Age

Male

Female

^(k)

Choose your level of benefits: Schedule: [A D E] ⁽ⁿ⁾

Requested Effective Date

____ / ____ / ____
Month Day Year

Payment Options: [ABW (monthly) Monthly Quarterly Semiannual Annual] ^(o)

[Modal Premium Selected \$ _____

Monthly Premium \$ _____

] ^(p)

Optional Life Insurance Application (Not required for issue of Medicare Supplement)

Life Policy [L728, Modified Whole Life Insurance] (r) Underwritten by Physicians Life Insurance Company

Face Amount:

[\$5,000 \$6,000 \$7,000 \$8,000 \$9,000 \$10,000] (s)

Optional Accidental Death Benefit (Rider LR-49):

[\$5,000 \$6,000 \$7,000 \$8,000 \$9,000 \$10,000] (t)

Beneficiary's Name

First Middle Initial Last

Relationship to Insured (u)

Contingent Beneficiary's Name

First Middle Initial Last

Relationship to Insured (q)

Do you have any existing life insurance or annuities? Yes No

[If yes, the Replacement of Life Insurance or Annuities form must be completed.] (v)

[In the event of nonpayment of premiums, do you wish to use part of your cash value (if any) as a loan to pay the past due amount to keep your coverage in force? Yes No] (w)

[Requested Effective Date

Month / Day / Year] (x)

Payment Options: [ABW (monthly) Monthly Quarterly Semiannual Annual] (y)

[Modal Premium Selected \$ Monthly Premium \$] (z)

This statement applies only to the Medicare Supplement application: The Undersigned applicant and insurance producer certify that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the Medicare Supplement policy.

I represent and agree that all information stated in this application is complete and correct to the best of my knowledge.

This statement applies only to applicants enrolling for optional Dental Certificate C250: I am enrolling for Certificate C250 and the plan selected issued to the Delaware Group Insurance Trust. I understand no coverage is in force until the Company issues a certificate showing a Certificate Effective Date and the first full premium has been paid. This Product is being purchased separately from the Medicare Supplement product. Benefits are not inclusive to the Medicare Supplement product. This product may be purchased without purchasing the Medicare Supplement product. (aa)

This statement applies only to applicants for optional Life Insurance Policy L728: I understand that the Life Insurance coverage I am applying for will not be in force until my application has been received by Physicians Life Insurance Company and my first premium has been paid during my lifetime. I also understand that a reduced death benefit amount is payable during the first two years. This Product is being purchased separately from the Medicare Supplement product. Benefits are not inclusive to the Medicare Supplement product. This product may be purchased without purchasing the Medicare Supplement product. (bb)

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

X

Applicant's Signature

Date Application Completed

Month / Day / Year

Dated at

City State

I represent and agree that I have truly and accurately recorded in this application all information supplied by the applicant and personally witnessed (his-her) signature. I also certify that only Company approved sales material was used in connection with this sale, and copies of all sales material used were left with the applicant.

This Medicare Supplement policy does replace does not replace any insurance presently in force.

[This Life Insurance policy (if applied for) does replace does not replace any insurance presently in force.] 

X _____

Licensed Resident Insurance Producer's Signature

Licensed Resident Insurance Producer's Printed Name

Licensed Resident Insurance Producer's NPN

X _____

Licensed Resident Insurance Producer's Signature

Licensed Resident Insurance Producer's Printed Name

Licensed Resident Insurance Producer's NPN

To Be Filled Out By Insurance Producer

1. List any other health insurance policies you have sold the applicant which are still in force:

2. List any other health insurance policies you have sold the applicant in the past five (5) years which are no longer in force:

Statement of Variability
Application M-NB-MSA001-AR-T
Revised 04/05/11

- a. May delete from the title if option to enroll in dental coverage is removed from the application.
- b. May delete from the title if option to apply for life coverage is removed from the application.
- c. May delete this item, or add/delete/change instructional copy.
- d. May delete this item, or add/delete/change instructional copy.
- e. May rearrange the layout or change format of this section. May change location of this section in the application. May delete/change items or add/change instructional copy.
- f. May rearrange the layout or change format of this section. May change location of this section in the application. May add/delete/change Plans offered, or modify plan names or add instructional copy.
- g. May add/move/delete/change the payment method options, as well as instructional copy.
- h. May add/move/delete/change premium information, as well as instructional copy.
- i. Will not change wording to health questions 10 and 11, but may delete questions 10 and 11 and instructional copy preceding and following those questions if we change the application to have all ages of applicants answer all the same health questions. Other question numbers would be renumbered accordingly.
- j. May delete instructional copy preceding question 12 if we change the application to have all ages of applicants answer all the same health questions. Other question numbers would be renumbered accordingly.
- k. May rearrange the layout or change format of this section. May change location of this section in the application. May delete this section.
- l. May add/delete/change Plans offered.
- m. May delete/change spouse information requested, or add instructional copy.
- n. May add/delete/change Schedules offered.

- o. May add/move/delete/change the payment method options, as well as instructional copy.
- p. May add/move/delete/change premium information, as well as instructional copy.
- q. May rearrange the layout or change format of this section. May change location of this section in the application. May delete this section.
- r. May add/delete/change Policies offered.
- s. May add/delete/change Face Amounts offered.
- t. May add/delete/change Riders offered. May add/delete/change Face Amounts of Riders offered.
- u. May add/delete/change the number of beneficiaries and/or contingent beneficiaries listed. May add/delete/change instructional copy.
- v. May delete this item, or add/change instructional copy.
- w. May delete if plans offered do not have a cash value.
- x. May delete this item, or add/change instructional copy.
- y. May add/move/delete/change the payment method options, as well as instructional copy.
- z. May add/move/delete/change premium information, as well as instructional copy.
- aa. May delete this item if dental insurance is not offered. May add/change/delete plan(s) offered.
- bb. May delete this item if life insurance is not offered. May add/change/delete plan(s) offered.
- cc. May delete this item if life insurance is not offered.
- dd. May delete this item if life insurance is not offered.

