Filing at a Glance

Company: Combined Insurance Company of America

Product Name: Senior Medicare Supplement Reinstatement Application	SERFF Tr Num: CMBD-127296403	State: Arkansas
TOI: MS09 Medicare Supplement - Other 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 49283
Sub-TOI: MS09.000 Medicare Supplement Other 2010	Co Tr Num: 149282	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Stephanie Fowler
	Author: Sue Thill	Disposition Date: 08/12/2011
	Date Submitted: 07/12/2011	Disposition Status: Approved-Closed
Implementation Date Requested: 08/01/2011		Implementation Date:

State Filing Description:

General Information

Project Name: Medicare Supplement Reinstatement Application
Project Number: 149282
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Sue Thill
Filing Description:
Combined Insurance Company of America
FEIN Number 36-2136262
NAIC Number 626-62146
Form Number: 149282
INDIVIDUAL MEDICARE SUPPLEMENT

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 08/12/2011
State Status Changed: 08/12/2011
Created By: Sue Thill
Corresponding Filing Tracking Number:

The above captioned form is attached for your consideration. Also attached is the following:

1. Variability Memorandum

The filing fee, in the amount of $50.00, was provided through EFT.

Reinstatement Application Form No.149282 is a new form and will not replace any existing reinstatement application. The application will be used with the following Medicare Supplement policies.

Form Numbers Description Approval Date SERFF Tracking/State Tracking #

14910-AR-A Plan A August 3, 2010 CMBD-126734449/46289
14911-AR-F Plan F August 3, 2010 CMBD-126734449/46289
14912-AR-N Plan N August 3, 2010 CMBD-126734449/46289

Thank you for your review.

Company and Contact

Filing Contact Information

Sue Thill, Senior Policy Analyst Sue.A.Thill@combined.com
1000 Milwaukee Avenue 847-953-1536 [Phone]
Glenview, IL 60025 847-953-1557 [FAX]

Filing Company Information

Combined Insurance Company of America	CoCode: 62146	State of Domicile: Illinois
1000 Milwaukee Avenue	Group Code: 626	Company Type:
Glenview, IL 60025	Group Name:	State ID Number:
(847) 953-1531 ext. [Phone]	FEIN Number: 36-2136262	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	1 APPLICATION X $50 = $50
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #

Combined Insurance Company of America	$50.00	07/12/2011	49694238

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	08/12/2011	08/12/2011

Disposition

Disposition Date: 08/12/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMBD-127296403*	*State:*	*Arkansas*
Filing Company:	*Combined Insurance Company of America*	*State Tracking Number:*	*49283*
Company Tracking Number:	*149282*		
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*Senior Medicare Supplement Reinstatement Application*		
Project Name/Number:	*Medicare Supplement Reinstatement Application/149282*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	VARIABILITY MEMORANDUM	Approved	Yes
Form	REINSTATEMENT APPLICATION	Approved	Yes

Form Schedule

Lead Form Number: 149282

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 08/12/2011	149282	Application/ Enrollment Form	REINSTATEMENT APPLICATION	Initial			149282.pdf

MEDICARE SUPPLEMENT REINSTATEMENT

FORM: 149282

COMBINED INSURANCE COMPANY OF AMERICA
("Combined") [111 East Wacker Drive, Suite 700, Chicago, IL 60601]
I am reapplying to Combined for a policy to be re-issued on the basis of the statement below:

7601149282

REINSTATEMENT APPLICATION NUMBER [7 6 0 1]

REINSTATEMENT

This application can only be used for **MEDICARE SUPPLEMENT**

APPLICANT'S PERSONAL INFORMATION

LANGUAGE PREFERENCE X E X S X F

M F INSURED'S FIRST NAME MIDDLE INITIAL LAST NAME

INSURED'S RESIDENCE ADDRESS

CITY STATE ZIP

Do you have a mobile phone? X YES X NO PHONE NUMBER

Do you have a landline phone? X YES X NO PHONE NUMBER

EMAIL

May we contact you by email for marketing purposes? X YES X NO

INSURED'S DATE OF BIRTH MM DD YYYY INSURED'S AGE

INSURED'S BILLING ADDRESS IF DIFFERENT FROM RESIDENCE

CITY STATE ZIP

POLICY NUMBER

1. Have you used any form of tobacco in the last 12 months? X YES X NO

2. Do you have another Medicare Supplement policy in force? X YES X NO

3. Are you covered for medical assistance through the state Medicaid program? X YES X NO

[NOTE TO APPLICANT: If you are participating in a "Spend-down Program" and have not met your "Share of Cost," please answer NO to this question]

If Yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy? X YES X NO

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? X YES X NO

IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED "YES", THE APPLICANT IS UNINSURABLE.

HAVE YOU RECEIVED ANY MEDICAL ADVICE INCLUDING REFERRALS FROM ANOTHER PHYSICIAN FOR DIAGNOSTIC TESTS OR SURGERY FROM A MEMBER OF THE MEDICAL PROFESSION OR TAKEN ANY MEDICATION IN THE PAST TWO YEARS FOR:

1. Stroke, TIA (Mini Stroke), Heart Attack, Congestive Heart Failure, Chronic Atrial Fibrillation or Coronary Artery Disease? ☐ YES ☐ NO
2. Cancer (excluding Skin Cancer), Leukemia, Hodgkins' Disease, Melanoma or any other type of Cancer? ☐ YES ☐ NO
3. Alzheimer's Disease, Dementia, Parkinson's Disease, Lou Gehrig's Disease/ALS, Multiple Sclerosis or Muscular Dystrophy? ☐ YES ☐ NO
4. Chronic Obstructive Pulmonary Disease, Chronic Bronchitis or Emphysema? ☐ YES ☐ NO
5. Manic Depression, Bipolar Disorder or Mental or Nervous Disorder requiring Psychiatric Care? ☐ YES ☐ NO
6. Alcoholism, Drug Addiction, Cirrhosis of the Liver, Kidney Failure or Insulin Dependent Diabetes? ☐ YES ☐ NO
7. Crippling or Debilitating Arthritis? ☐ YES ☐ NO
8. Oxygen Therapy, Kidney Dialysis, a Defibrillator, Pacemaker, Coronary Bypass Surgery, Angioplasty or Stent placement? ☐ YES ☐ NO
9. Diagnosis or treatment by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for HIV? ☐ YES ☐ NO
10. Do you require or receive any assistance with any of your activities of daily living such as bathing, transferring, toileting, eating, dressing or continence? ☐ YES ☐ NO
11. Do you currently use any durable medical equipment such as a 4 prong cane, walker, wheelchair or motorized aid? ☐ YES ☐ NO

WITHIN THE PAST TWO (2) YEARS HAVE YOU HAD ANY MEDICAL ADVICE (INCLUDING REFERRALS TO OTHER PHYSICIANS FOR DIAGNOSTIC TESTS AND SURGERY) OR TREATMENT FROM A MEMBER OF THE MEDICAL PROFESSION OR TAKEN ANY PRESCRIPTION MEDICATION FOR ANY OTHER MEDICAL CONDITION(S) NOT LISTED ABOVE? ☐ YES ☐ NO

(IF NO, PLEASE INCLUDE PRIMARY PHYSICIAN'S NAME, ADDRESS AND PHONE NUMBER)

MEDICAL CONDITION (If hospitalized, provide dates)	DATE OF DIAGNOSIS	TYPE OF TREATMENT if currently receiving treatment	PHYSICIAN NAME, ADDRESS (Street, City, State, Zip) AND PHONE NUMBER

PLEASE LIST ALL MEDICATIONS (PRESCRIPTION OR NON-PRESCRIPTION) YOU ARE CURRENTLY TAKING AND THE REASON FOR TAKING THEM IN THE SECTION BELOW:

NAME OF MEDICATION	DOSAGE AND FREQUENCY PER DAY	MEDICAL CONDITION

AUTHORIZATION

To the best of my knowledge and belief, my answers are true and correct. I acknowledge receipt of the Outline of Coverage that describes the Policy for which I am applying, the pamphlet entitled, "Guide to Health Insurance for People with Medicare" and the Notice of Information Practices.

I authorize Combined Insurance Company of America or its reinsurers for the purpose of evaluating this application for insurance to acquire, review, research the release of information from the following: Medical Professional; Hospital; Physician; Medical Practitioner; Clinic; Pharmacy; Pharmacy Benefits Manager or other pharmacy-related services organization; Health Plan; other medical or medically-related facilities; Government Agency; Medical Information Bureau, Inc., (MIB); Consumer Reporting Agency; Combined's own records. Combined Insurance Company of America will acquire through a personal phone interview or another means from the above any needed information on the Insured, his/her dependents including but not limited to copies of records, concerning advice, care or treatment, on past or present health, the use of drugs or alcohol, and information relating to mental illness. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization will remain valid for a period of two years from the application date of the policy. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to Combined.

You may revoke this authorization at any time by writing Combined; however, such revocation may affect coverage.

Failure to sign this authorization may impair the ability of Combined to evaluate or process this application and may be a basis for denying this application.

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.

X _____ Date of Application: MM DD YYYY

Signature of Insured

City (where signed): _____ State: _____

[_____ _____ Date: MM DD YYYY]

Agent's/Producer's Signature Agent Code

Primary Agent/Producer contact information

Agent's/Producer's phone
Agent's/Producer's e-mail address
Agent's/Producer's cell phone

Home Office use only

Complete this area when splitting commissions.	
Primary	Secondary
Agent/Producer Name	Agent/Producer Name
Code #	Code #
Percentage	Percentage
Agent's/Producer's Signature	Agent's/Producer's Signature

7604149282

REINSTATEMENT APPLICATION NUMBER [7 6 0 4]

AUTOMATIC PREMIUM COLLECTION
(Automatic Premium for Monthly Mode ONLY)

Name of Financial Institution: City: State:

BANK ROUTING NUMBER BANK ACCOUNT NUMBER

Complete if adding policies from another application

NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUTION

Charge my Checking X Savings X Initial Premium Collected $ **Policy Type** (L = Life, H = Health)

Credit Card X Preferred Billing Date (1–28 only) Amount Charged

NAME OF CARDHOLDER CARDHOLDER ZIP CODE

ACCOUNT NUMBER EXPIRES MONTH YEAR CARD TYPE VISA X MC X

AUTHORIZATION FOR ELECTRONIC DEBIT

I hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercially accepted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to debit the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.

I understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy Premium and Benefit schedule.

I agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(ies) will terminate. Life policies may have non-forfeiture benefits.

PAYOR'S PHONE NUMBER

X Date: M M D D Y Y Y Y

Signature of Payor (Signature must be the same as on file at the bank/financial institution) X Mobile X Landline

Application No.	

Amount of Insurance	$

COMBINED INSURANCE COMPANY OF AMERICA • [111 East Wacker Drive • Suite 700 • Chicago, IL 60601]

MEDICARE SUPPLEMENT INSURANCE APPLICATION RECEIPT

I have applied for an insurance policy from Combined Insurance Company of America (Combined). With my application I have submitted a check, money order or cash in the amount of $_____. This receipt shall be void and no coverage applied for will not take affect if any check, draft or money order given in payment of the first premium is not honored.

I understand that this payment will be held by Combined and, if my application is approved and a policy is issued to me, Combined will accept this payment and apply it as the premium for the first period of coverage under the policy.

I understand that this policy will **NOT** become effective unless my application is approved in writing by Combined and a policy is delivered to me. I understand that if Combined approves my application, I will have coverage beginning on the date of such approval by Combined. If my application is not approved by Combined, the above premium will be refunded to me within 60 days of denial. I understand that in no event will I have coverage for the period between today and the date on which Combined approves or disapproves my application.

Proposed Insured's Signature: _____ Date: _____

Agent's Signature: _____ Agent Code: _____ Date: _____

Form No. 149282-Receipt

Home Office Copy
(remains with application)

7604149282

REINSTATEMENT APPLICATION NUMBER [7 6 0 4]

AUTOMATIC PREMIUM COLLECTION
(Automatic Premium for Monthly Mode ONLY)

Name of Financial Institution: City: State:

BANK ROUTING NUMBER BANK ACCOUNT NUMBER

Complete if adding policies from another application

NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUTION

Charge my Checking X Savings X Initial Premium Collected $ **Policy Type** (L = Life, H = Health)

Credit Card X Preferred Billing Date (1–28 only) Amount Charged

NAME OF CARDHOLDER CARDHOLDER ZIP CODE

ACCOUNT NUMBER EXPIRES MONTH YEAR CARD TYPE VISA X MC X

AUTHORIZATION FOR ELECTRONIC DEBIT

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PAYOR'S PHONE NUMBER

X Date: MM DD YYYY

Signature of Payor (Signature must be the same as on file at the bank/financial institution) X Mobile X Landline

Application No.	

Amount of Insurance	$

COMBINED INSURANCE COMPANY OF AMERICA • [111 East Wacker Drive • Suite 700 • Chicago, IL 60601]

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Proposed Insured's Signature: _____ Date: _____

Agent's Signature: _____ Agent Code: _____ Date: _____

Form No. 149282-Receipt

Applicant Copy

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification		
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application		
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	VARIABILITY MEMORANDUM	Approved	08/12/2011
Comments:			

Attachment:

Variability Memorandum Reinstatement Application.pdf

Combined Insurance Company of America

VARIABILITY MEMORANDUM

Medicare Supplement Reinstatement Application Form No. 149282

Company Address	Bracketed to allow for future change without re-filing.
Dates	Bracketed to allow for future change without re-filing.
Language Preference	Bracketed to allow for future change without re-filing.
E-mail Question	Bracketed to allow for future change without re-filing.
Agent/Producer Signature, Code and Date	Bracketed to allow for future change without re-filing.
Agent/Producer Contact Information	Bracketed to allow for future change without re-filing
Home Office Information	Bracketed to allow for future change without re-filing
Billing Mode	Bracketed to allow for future change without re-filing.
Credit Card Information	Bracketed to allow for future change without re-filing.