

SERFF Tracking Number: GRTT-127897514 State: Arkansas
Filing Company: Guarantee Trust Life Insurance Company State Tracking Number: 50480
Company Tracking Number:
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
Product Name: APPH8-11-AZ
Project Name/Number: Medicare Supplement Application/

Filing at a Glance

Company: Guarantee Trust Life Insurance Company

Product Name: APPH8-11-AZ

SERFF Tr Num: GRTT-127897514 State: Arkansas

TOI: MS09 Medicare Supplement - Other 2010 SERFF Status: Closed-Approved-
Closed State Tr Num: 50480

Sub-TOI: MS09.000 Medicare Supplement
Other 2010

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Authors: Al Heindl, Ann Ryan

Reviewer(s): Stephanie Fowler

Date Submitted: 12/14/2011

Disposition Date: 01/05/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Medicare Supplement Application

Status of Filing in Domicile: Pending

Project Number:

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: 01/05/2012

State Status Changed: 01/05/2012

Deemer Date:

Created By: Ann Ryan

Submitted By: Ann Ryan

Corresponding Filing Tracking Number:

Filing Description:

NAIC #64211 687

FEIN #36-1174500

Dear Sir or Madam:

We are submitting the above referenced application for your review and approval.

Application form APPH8-11-AR does not replace any previously approved application form. We are asking for general approval of this application. It will be used with our currently approved, as well as future generations of Medicare

SERFF Tracking Number: GRTT-127897514 State: Arkansas
 Filing Company: Guarantee Trust Life Insurance Company State Tracking Number: 50480
 Company Tracking Number:
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
 Product Name: APPH8-11-AZ
 Project Name/Number: Medicare Supplement Application/
 Supplement plans.

These forms have been printed by our computer and laser printer. We reserve the right to change the font (typeset) when and if a new font becomes available.

We would appreciate any consideration you could extend toward the prompt approval of this submission. If I can be of further assistance in the approval process, please contact me directly by E-mail or at our toll-free number shown below.

Company and Contact

Filing Contact Information

Ann Ryan, aryan@gtlic.com
 1275 Milwaukee Ave. 847-904-5587 [Phone] 5587 [Ext]
 Glenview, IL 60025 847-699-0093 [FAX]

Filing Company Information

Guarantee Trust Life Insurance Company CoCode: 64211 State of Domicile: Illinois
 1275 Milwaukee Avenue Group Code: 687 Company Type: Mutual
 1275 Milwaukee Avenue Group Name: State ID Number:
 Glenview, IL 60025 FEIN Number: 36-1174500
 (847) 460-4772 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: AR fee is \$50 for application, IL fee is \$50 per form.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Guarantee Trust Life Insurance Company	\$50.00	12/14/2011	54540773

SERFF Tracking Number: GRTT-127897514 State: Arkansas
Filing Company: Guarantee Trust Life Insurance Company State Tracking Number: 50480
Company Tracking Number:
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
Product Name: APPH8-11-AZ
Project Name/Number: Medicare Supplement Application/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	01/05/2012	01/05/2012

SERFF Tracking Number: GRTT-127897514 State: Arkansas
Filing Company: Guarantee Trust Life Insurance Company State Tracking Number: 50480
Company Tracking Number:
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
Product Name: APPH8-11-AZ
Project Name/Number: Medicare Supplement Application/

Disposition

Disposition Date: 01/05/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *GRTT-127897514* *State:* *Arkansas*
Filing Company: *Guarantee Trust Life Insurance Company* *State Tracking Number:* *50480*
Company Tracking Number:
TOI: *MS09 Medicare Supplement - Other 2010* *Sub-TOI:* *MS09.000 Medicare Supplement Other 2010*
Product Name: *APPH8-11-AZ*
Project Name/Number: *Medicare Supplement Application/*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes

SERFF Tracking Number: GRTT-127897514 State: Arkansas
 Filing Company: Guarantee Trust Life Insurance Company State Tracking Number: 50480
 Company Tracking Number:
 TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
 Product Name: APPH8-11-AZ
 Project Name/Number: Medicare Supplement Application/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	01/05/2012

Comments:
Flesch certification

Attachment:
Readability Certification for APPH8-11-AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	01/05/2012

Comments:
Application

Attachment:
APPH8-11-AR.pdf

		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:			

CERTIFICATE OF READABILITY

Form Number(s): APPH8-11-AR

Flesch Test Score(s): 50.71

I hereby certify that to the best of my knowledge and belief, the above form(s) meet the minimum reading ease requirements of your Department. The Flesch Reading Ease Test score(s) are listed above.

GUARANTEE TRUST LIFE INSURANCE COMPANY



Allan J. Heindl, FLMI, HIA, AIRC
Vice President – Product Approval & Compliance

Date: December 14, 2011

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 MILWAUKEE AVENUE • GLENVIEW • ILLINOIS 60025 • 1-800-338-7452

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

APPLICANT		Last Name			First Name			M.I.	
Soc. Security #		Age	Date of Birth	Sex	Height	Weight	Phone Number	E-mail Address	
			/ /				()		
ADDRESS Number & Street				City			State	Zip Code	

PLAN & PAYMENT INFORMATION	
<p>1. Requested Effective Date or Replacement Date: _____</p> <p>2. I am applying for:</p> <p style="padding-left: 20px;">Medicare Supplement Plan:</p> <p style="padding-left: 40px;"><input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> N</p>	<p>3. Premium Mode:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual</p> <p style="padding-left: 20px;"><input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Bank Draft*</p> <p>Requested Draft Date _____</p> <p>Total Modal Premium: \$ _____</p> <p>Premium Paid with Application: \$ _____</p> <p>* 1 month's premium required for bank draft</p>

MEDICARE COVERAGE QUESTIONS Questions 4 through 9 must be answered.

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 of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.
PLEASE ANSWER ALL OF THE QUESTIONS COMPLETELY.
Please mark Yes or No with an "X". To the best of your knowledge:

<p>4. Are you covered under Medicare Parts A & B? (If the answer is "No", do not submit the application) If yes, what is your Medicare claim number? (exactly as it appears on your Medicare Card) _____</p> <p>5. Are you covered for medical assistance through the state Medicaid program? (If the answer to 5a. or 5b. is "yes", do not submit the application.) 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 you answer yes,</p> <p style="padding-left: 20px;">a. Will Medicaid pay your premiums for this Medicare supplement policy?</p> <p style="padding-left: 20px;">b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?....</p> <p>6. a. Did you turn age 65 in the last 6 months?</p> <p style="padding-left: 20px;">b. Did you enroll in Medicare Part B in the last 6 months or will you enroll in Medicare Part B in the next 6 months? If yes, what is/was the effective date? _____</p> <p>7. a. Do you have another Medicare supplement policy in force?.....</p> <p style="padding-left: 20px;">b. If so, with what company and what plan do you have? _____</p> <p style="padding-left: 20px;">c. If so, do you intend to replace your current Medicare supplement policy with this policy?.....</p> <p>8. a. 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 ____/____/____ END ____/____/____</p> <p style="padding-left: 20px;">b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
---	---

<p>c. Was this your first time in this type of a Medicare plan?</p> <p>d. Did you drop a Medicare supplement policy to enroll in the Medicare plan?</p> <p>9. Have you had coverage under any other health insurance within the past 63 days?..... (For example, Railroad Retirees, teachers plans, an employer union, group major medical 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? START ____/____/____ END ____/____/____ (If you are still covered under the other policy, leave the "END" blank.)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

HEALTH QUESTIONS	Questions 10 through 18 must be answered.
-------------------------	--

If you have enrolled in Medicare Part B within the past 6 months, you do not have to answer the following questions. Otherwise you must answer the following questions. Please note, if you answer "yes" to any question 10 through 15, you are not eligible for coverage.

<p>10. In the past 24 months have you had or been advised to receive treatment for:</p> <p>a. Internal cancer, malignant melanoma, insulin dependent diabetes, heart disease (High Blood Pressure not included), heart or valve surgery, congestive heart failure, stroke or Transient Ischemic Attack, kidney failure or dialysis?</p> <p>b. Organ transplant (other than cornea), multiple sclerosis, muscular dystrophy, ALS (Lou Gehrig's disease), myasthenia gravis, Alzheimer's Disease, dementia, or memory loss?</p> <p>c. Alcohol or drug abuse, amputation due to disease, disabling arthritis, cirrhosis, or Parkinson's disease?.....</p> <p>11. In the past 24 months, have you:</p> <p>a. Been hospitalized for a mental or nervous disorder or chronic lung disorder?</p> <p>b. Been in a nursing home or assisted living facility?</p> <p>12. Are you currently bedridden, or in a hospital, nursing home, assisted living facility, long term care facility, or receiving home health care or do you expect to be so confined or require home health care in the next 60 days?.....</p> <p>13. Do you require the use of a wheelchair, oxygen to aid in breathing or require assistance in eating or dressing or do you require an authorized person to act on your behalf legally due to a physical or mental disease or disorder?</p> <p>14. Have you been advised to have inpatient surgery but have not yet done so or have you been hospitalized more than 2 times in the past year?</p> <p>15. Have you been diagnosed by a member of the medical profession for Acquired Immune Deficiency (AIDS), AIDS Related Complex (ARC), or tested positive for the antibodies to AIDS, or human immunodeficiency virus (HIV)?</p> <p>16. Have you used any tobacco products in the past 12 months?</p> <p>17. Please provide your doctor's name, address, and telephone number.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

Doctor's Name	Address	Phone
---------------	---------	-------

18. Please list all prescription medications you are currently taking (if none, indicate so).

Medication	Dosage	Condition

DISCLOSURE & AUTHORIZATION

DISCLOSURE: You do not need more than one Medicare supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. 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.

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 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).

APPLICANT'S AUTHORIZATION & AGREEMENT: I authorize Guarantee Trust Life Insurance Company (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my physical condition, other coverage and any other information needed to underwrite my application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, pharmacy benefit manager, pharmacy, pharmacy-related facility, insurance company or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from the Medical Information Bureau. This Authorization includes all information about drugs, alcoholism, and mental illness. I agree that this Authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it. Although federal regulations require that the Company inform Me (Us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as the Company has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my agent or to the attention of the Underwriting Manager.

I also understand that my application for insurance can be declined if I choose not to sign this Authorization.

ACKNOWLEDGEMENTS: The Applicant represents and agrees as follows: 1) That the statements contained in the application concerning past and present health are complete. 2) Any coverage issued as a result of this application shall, together with this application, constitute a single and entire contract of insurance. 3) No agent or any other person is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Company's rights or requirements. 4) Any insurance issued as a result of the application will not take effect unless and until the full first premium is paid and the policy is delivered during such person's lifetime. 5) Provisions concerning exceptions, exclusions, limitations and renewal of the insurance plan which has been applied for, have been explained and are understood. 6) The applicant shall be owner of any insurance applied for. 7) The applicant acknowledges receipt of the Outline of Coverage, and has read the authorization and received copies of the "Notice to Applicant, Parts 1 and 2" describing the Medical Information Bureau and explaining the rights of the applicant under the Fair Credit Reporting Act.

AGREEMENT: I have read, or had read to me, the completed application. I hereby agree that: 1) all the statements and answers in this application are complete and true to the best of my knowledge and belief; and 2) **no insurance will be effective until my policy is issued.**

Caution: If your answers on this application are incorrect or untrue, Guarantee Trust Life Insurance Company may deny benefits or rescind your policy.

We are required to give you this notice: Any person who, with the intent to defraud or knowledge that he is facilitating a fraud against the insurer, submits an application or files a claim containing false, incomplete, or deceptive statements of material fact may be guilty of insurance fraud.

Applicant's Signature

City & State signed

Date

AGENT'S REPORT: List of health policies or certificates I have sold to the Applicant in the last 5 years which are either in force or no longer in force:

NAME OF INSURER	POLICY TYPE

AGENT'S STATEMENT

I certify: 1) I have accurately recorded the information supplied by the Applicant; 2) I have given an Outline of Coverage for the policy being applied for and the Medicare Supplement Buyer's Guide to the Applicant; 3) I am or am not aware the policy applied for will replace an existing health insurance policy; and 4) I have reviewed the current health coverage of the Applicant and have completed the chart above, as applicable. I find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.

Agent's Signature

Agent's Name (please print)

Agent Code

Agent's E-mail Address

(Agent signature not required if sold through the mail.)

TYPE OF SALE:

In Person

Telephone

On-line

Mail

MONTHLY PRE-AUTHORIZED PREMIUM PAYMENT PLAN

Authorization to Honor Withdrawals to be drawn by Guarantee Trust Life Insurance Company.

TO _____
Name of my Bank

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of Guarantee Trust Life Insurance Company, Glenview, Illinois, provided there are sufficient funds in my account to pay the same upon presentation.

Account #: _____ Bank Routing #: _____

Account Type Checking Account (*Attach a Voided "Sample" check*) Savings Account (*Attach a Voided "Sample" check if applicable, or a Deposit slip*)

I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I further agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

Printed name of insured if different from premium payer

Premium payer's signature, as it appears on bank records

RECEIPT

DATE _____

Received of _____ the sum of \$ _____ and application for insurance to Guarantee Trust Life Insurance Company. If for any reason the application is declined this payment will be refunded. No liability is created or assumed by the Company, except for refund of this payment, until the insurance applied for has been issued.

Agent's Signature : _____

If you do not receive your policy within 60 days from the date of your application, please write to:
Guarantee Trust Life Insurance Company, 1275 Milwaukee Avenue, Glenview, IL 60025

MAKE CHECK PAYABLE TO:
GUARANTEE TRUST LIFE INSURANCECOMPANY