

SERFF Tracking Number: STLG-128209822 State: Arkansas
Filing Company: Sterling Life Insurance Company State Tracking Number:
Company Tracking Number: AR NHD 2012
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
Standard Plans 2010
Product Name: AR NHD 2012
Project Name/Number: /

Filing at a Glance

Company: Sterling Life Insurance Company

Product Name: AR NHD 2012

TOI: MS08I Individual Medicare Supplement -
Standard Plans 2010

Sub-TOI: MS08I.001 Plan A 2010

Filing Type: Form

SERFF Tr Num: STLG-128209822 State: Arkansas

SERFF Status: Closed-Accepted State Tr Num:
For Informational Purposes

Co Tr Num: AR NHD 2012

State Status: Filed-Closed

Reviewer(s): Stephanie Fowler

Authors: Jennifer Marinas, Rich

Disposition Date: 04/10/2012

Phillips, Allison Hulbert, Keri Gates

Date Submitted: 04/04/2012

Disposition Status: Accepted For
Informational Purposes

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

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: 04/10/2012

State Status Changed: 04/10/2012

Deemer Date:

Created By: Keri Gates

Submitted By: Keri Gates

Corresponding Filing Tracking Number:

Filing Description:

Re: Sterling Life Insurance Company Medicare Standard Medicare Supplement Insurance Filing: FORM

NAIC # 77399

NAIC Group #361

Form Filing for approval:

Medicare Supplement SELECT:

SERFF Tracking Number: STLG-128209822 State: Arkansas
Filing Company: Sterling Life Insurance Company State Tracking Number:
Company Tracking Number: AR NHD 2012
TOI: MS081 Individual Medicare Supplement - Sub-TOI: MS081.001 Plan A 2010
Standard Plans 2010
Product Name: AR NHD 2012
Project Name/Number: /

Medicare Select Plan A – Form Number: AR SEL A (05/10)
Medicare Select Plan B – Form Number: AR SEL B (05/10)
Medicare Select Plan C – Form Number: AR SEL C (05/10)
Medicare Select Plan F – Form Number: AR SEL F (05/10)
Medicare Select Plan G – Form Number: AR SEL G (05/10)
Medicare Select Plan K – Form Number: AR SEL K (05/10)
Medicare Select Plan N – Form Number: AR SEL N

Dear Sir/Madam

Please find the following for approval. The hospital network directory in this filing is for the updated hospital network for Medicare Select plans for this state. The changes made to these directories include the updated network of hospitals as of April 2012. The previous filings for these directories are also attached, but have no approval number from being filed before SERFF.

If you have questions or concerns please do not hesitate to contact me at 360-392-9371 or email keri.gates@sterlinginsurance.com.

Sincerely,
Keri Gates
Product Implementation Coordinator
Product Development
State Narrative:

Company and Contact

Filing Contact Information

Keri Gates, Project Technician II
P.O. Box 5348
2219 Rimland Drive
Bellingham, WA 98227-5348
keri.gates@windsorhealthgroup.com
360-392-9371 [Phone]

Filing Company Information

Sterling Life Insurance Company
P.O. Box 5348
Bellingham, WA 98227
(360) 647-9080 ext. [Phone]

CoCode: 77399
Group Code: 361
Group Name:
FEIN Number: 13-1867829

State of Domicile: Illinois
Company Type: Insurance
Company - Life, Accident & Health
State ID Number:

SERFF Tracking Number: STLG-128209822 State: Arkansas
Filing Company: Sterling Life Insurance Company State Tracking Number:
Company Tracking Number: AR NHD 2012
TOI: MS081 Individual Medicare Supplement - Sub-TOI: MS081.001 Plan A 2010
Standard Plans 2010
Product Name: AR NHD 2012
Project Name/Number: /

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---------------------------------|---------|----------------|---------------|
| Sterling Life Insurance Company | \$50.00 | 04/04/2012 | 57734710 |

SERFF Tracking Number: STLG-128209822 State: Arkansas
Filing Company: Sterling Life Insurance Company State Tracking Number:
Company Tracking Number: AR NHD 2012
TOI: MS081 Individual Medicare Supplement - Sub-TOI: MS081.001 Plan A 2010
Standard Plans 2010
Product Name: AR NHD 2012
Project Name/Number: /

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-------------------------------------|------------------|------------|----------------|
| Accepted For Informational Purposes | Stephanie Fowler | 04/10/2012 | 04/10/2012 |

SERFF Tracking Number: STLG-128209822 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number:
 Company Tracking Number: AR NHD 2012
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
 Standard Plans 2010
 Product Name: AR NHD 2012
 Project Name/Number: /

Form Schedule

Lead Form Number: AR NHD

| Schedule Item | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|--|----------------|-----------|-----------------------------------|---------|----------------------|-------------|--------------------|
| Accepted for Informational Purposes 04/10/2012 | AR NHD (04/12) | Other | Select Network Hospital Directory | Initial | | | AR NHD (04.12).pdf |



STERLING MEDICARE SUPPLEMENTSM

**Medicare Select Network Hospital Directory
ARKANSAS**

| Hospital | Hospital Address | Phone Number |
|---|--|----------------|
| ◆ Benton County | | |
| Northwest Medical Center - Bentonville | 3000 Medical Center Parkway Bentonville, AR 72712 | (479) 553-1000 |
| ◆ Crittenden County | | |
| Crittenden Memorial Hospital | 200 Tyler Street West Memphis, AR 72303 | (870) 735-1500 |
| ◆ Cross County | | |
| CrossRidge Community Hospital | 310 South Falls Boulevard Wynne, AR 72396 | (870) 238-3300 |
| ◆ Garland County | | |
| National Park Medical Center | 1910 Malvern Avenue Hot Springs National Park, AR 71901 | (501) 321-1000 |
| ◆ Logan County | | |
| Booneville Community Hospital | 880 W Main Street Booneville, AR 72927 | (479) 675-2800 |
| ◆ Pulaski County | | |
| St. Vincent Doctors Hospital | 2 Saint Vincent Circle Little Rock, AR 72205 | (501) 660-3000 |
| St. Vincent Health System | 6101 W Capitol Little Rock, AR 72205 | (501) 522-6000 |
| St Vincent Medical Center - North | 2215 Wildwood Avenue Sherwood, AR 72120 | (501) 552-7100 |
| ◆ Sebastian County | | |
| Advance Care Hospital of Fort Smith | 7301 Rogers Avenue Fort Smith, AR 72903 | (479) 314-4900 |
| Sparks Regional Medical Center | 1001 Towson Avenue Fort Smith, AR 72901 | (479) 441-4000 |
| Health South Rehabilitation of Fort Smith | 1401 South J Street Fort Smith, AR 72901 | (479) 785-3300 |

Underwritten by Sterling Life Insurance Company - A Windsor Health Group Company

[PH. 800-688-0010] [P.O. Box 5348, Bellingham, WA 98227-5348] [www.sterlinginsurance.com]



STERLING MEDICARE SUPPLEMENTSM
Medicare Select Network Hospital Directory
ARKANSAS

| Hospital | Hospital Address | Phone Number |
|---------------------------------------|--|---------------------|
| ♦ Washington County | | |
| Northwest Medical Center - Springdale | 609 W Maple Avenue Springdale, AR 72764 | (479) 751-5711 |
| ♦ White County | | |
| White County Medical Center South | 1200 South Main Street Searcy, AR 72142 | (501) 278-3100 |

SERFF Tracking Number: STLG-128209822 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number:
 Company Tracking Number: AR NHD 2012
 TOI: MS081 Individual Medicare Supplement - Sub-TOI: MS081.001 Plan A 2010
 Standard Plans 2010
 Product Name: AR NHD 2012
 Project Name/Number: /

Supporting Document Schedules

| | Item Status: | Status Date: |
|--|---------------------|-------------------------|
| Bypassed - Item: Flesch Certification | | |
| Bypass Reason: Flesch Certification N/A - NHD filing. | | |
| Comments: | | |

| | Item Status: | Status Date: |
|--|---------------------|-------------------------|
| Satisfied - Item: Application | | |
| Comments: | | |
| Attachment: AR MSPAPP Med Supp Application.pdf | | |

| | Item Status: | Status Date: |
|--|---------------------|-------------------------|
| Bypassed - Item: Health - Actuarial Justification | | |
| Bypass Reason: N/A - No change in rates. | | |
| Comments: | | |

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

STERLING HEALTH PLANS

Underwritten by Sterling Life Insurance Company®

Application for Medicare Supplement Insurance Arkansas

Applicant Information *Please include your full name as it appears on your Medicare ID Card*

| | | |
|---|----------------------|------------------------|
| Last Name | First Name | Middle Initial |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Resident Address | City | |
| <input type="text"/> | <input type="text"/> | |
| ST | Zip | County |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | | Primary Phone Number |
| | | <input type="text"/> |
| Billing Address (If different than above) | City | |
| <input type="text"/> | <input type="text"/> | |
| ST | Zip | County |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | | Secondary Phone Number |
| | | <input type="text"/> |
| Email Address | | |
| <input type="text"/> | | |

Medicare Information *As it appears on your Medicare ID Card*

Medicare ID # Part B Effective Date 0 1

Plan Selection, Effective Date & Premium Criteria

- Policy Choice:** (Select one) Standard SELECT
- Plan Choice:** (Select one)
 Plan A Plan B Plan C Plan F "Innovative" F Plan G Plan K Plan N
- Requested Future Effective Date - 1st of Month:**
- Age (on the Requested Effective Date)** **Date of Birth** **Gender** M F
- Payment Options:** [(Initial premium must be paid by check, money order or bank draft)]

Select Payment Type:

- Coupon** (Select billing period)
- Monthly Quarterly Semi-Annual Annual
- Monthly Automatic Premium Collection** (from your bank account).
Please complete & submit an APC Authorization form.
- Monthly Credit or Debit Card** [(Visa, MasterCard, Discover credit card or debit card with Visa or MasterCard logo)
Monthly coupon rate applies. [Please contact Customer Service at [1-800-688-0010] or TTY [711].]]

| |
|--|
| Premium Amount |
| \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> |

Eligibility

1. a) Did you turn age 65 in the last 6 months or will you prior to the plan effective date? Yes No
b) Did you enroll in Medicare Part B in the last 6 months or will you prior to the plan effective date? Yes No
2. Are you covered for medical assistance through the state Medicaid program? Yes No

If NO, proceed to Past and Current Coverage.

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 premium for this Medicare Supplement policy? Yes No
b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No



If you lost or are losing other health insurance coverage and received a notice from a 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 have 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.

Past and Current Coverage

1. If you had a Medicare Advantage policy within the past 63 days (For example, Medicare PFFS, HMO or PPO), fill in your start and end dates below. **If NO, proceed to question 2.**

a) If you are still covered under this plan, leave "END" blank.

START DATE MMDDYY END DATE MMDDYY

- b) If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare Supplement policy? Yes No
c) Was this your first time in this type of Medicare Advantage plan? Yes No
d) Did you cancel a Medicare Supplement policy prior to enrolling in this Medicare Advantage plan? Yes No
2. Do you have another Medicare Supplement policy in force? **If NO, proceed to question 3.** Yes No

a) **IF YES,** with what company,
... and what plan do you have?

b) **IF YES,** do you intend to replace your current Medicare Supplement policy with this policy? Yes No

3. Have you had ANY other health insurance within the past 63 days? (For example, an employer, union, or individual plan?) **If NO, proceed to next section.** Yes No

a) **IF YES,** with what company,
... and what plan do you have?

b) What are your dates of coverage for the policy listed in 3a?
If you are still covered under this plan, leave "END" blank.

START DATE MMDDYY END DATE MMDDYY



If question 1b or 2b is answered YES, then the Replacement of Coverage form must be signed and submitted with the application.

Health History and Medication Information



If you answered **YES** to 1a in the **Eligibility** section, or you qualify for another open enrollment or guaranteed issue period, you may proceed directly to Authorization and Verification of Information on the next page.

1. Please answer the following health questions:

- a) Are you currently hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, or have you received home health care in the past 90 days; or has such care been medically advised by a licensed medical practitioner? Yes No
- b) Have you been diagnosed or treated for Chronic Obstructive Lung / Pulmonary Disease or Emphysema? Yes No
- c) Have you been diagnosed or treated for Alzheimer’s Disease, Parkinson’s Disease, Lou Gehrig’s Disease or ALS, Multiple Sclerosis or Muscular Dystrophy? Yes No
- d) Have you been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for HIV virus? Yes No
- e) Have you been diagnosed or treated for Insulin Dependent Diabetes or Rheumatoid or Disabling Arthritis? Yes No
- f) Have you been admitted to a hospital three or more times in the last two years? Yes No
- g) Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes No
- h) Within the past two years, have you been treated for or been advised by a physician to have treatment for Cancer (excluding skin), Leukemia, Hodgkin’s’ Disease or Melanoma? Yes No
- i) Within the past two years, have you been treated for or been advised by a physician to have treatment for Stroke, Heart Attack, Coronary Artery Disease including Angina, Arteriosclerosis or Atherosclerosis or Congestive Heart Failure? Yes No
- j) Within the past two years, have you been treated for or been advised by a physician to have treatment for Alcoholism, Drug Addiction, Cirrhosis of the Liver, or Renal Failure? Yes No
- k) Within the past two years, have you received or been advised by a physician to have Oxygen Therapy, Kidney Dialysis, a Defibrillator, Bypass Surgery, Angioplasty, Pacemaker or Stent Placement? Yes No



If you answered **YES** to any question above, you are **NOT** eligible for coverage at this time.

- 2. Have you used **tobacco** in the last two years? Yes No
- 3. Please indicate your height and weight: FT. IN. / LBS.
- 4. Have you been hospitalized or admitted to an extended care facility in the last two years? Yes No
IF YES, please explain below:

| Date of Hospitalization | Disease, Injury, or Condition | Name of Operation Performed, if any | Name & Address of Physician |
|-------------------------|-------------------------------|-------------------------------------|-----------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

2. **Representation.** The undersigned applicant and agent acknowledge that the applicant has read or has had read to him/her the completed application and that he/she realizes that any false statements or misrepresentation therein may result in loss of coverage under the policy.
3. **Payment of Premium.** I acknowledge that I have read the Conditional Receipt and fully understand its conditions and limitations. I understand that no agent can waive or change the conditions and limitations of the Conditional Receipt.
4. **Release.** I authorize US Department of Health and Human Services (including Centers for Medicare and Medicaid Services and any contractors or agents), any physician, medical professional, hospital, clinic, pharmacy related services organization, health plan, or insurance company to disclose to Sterling or its reinsurers medical records, prescription records, or other such information upon presentation of this authorization or reproduction thereof. I understand the purpose of this disclosure and use of my information is to evaluate my application for insurance, to determine the amount payable for my claims, and for analytic studies. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for the term of the coverage being applied for and so long thereafter as permissible by law and may be revoked by sending written notice to Sterling. This authorization is a condition of your enrollment in our health plan and your eligibility for benefits.
5. **Agent.** List all policies you have sold to the applicant, including those no longer in force, if sold in the last five years (if none, state "none"):

Policies sold which are still in force:

Policies sold in the past 5 years which are no longer in force:

Applicant's Signature (Required)

Today's Date

 *If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.*

Agent Certification: I certify that the Applicant has read, or had read to him/her, the complete application and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for is or is likely; is not or is not likely to replace or change any existing policy (ies) or contract(s).

Signature of Licensed Agent

Agent #

Print Name Today's Date

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

 *If reply envelope is missing, please mail to the address below or fax to [(360) 685-5950].*