

SERFF Tracking Number: LFCR-128535647 State: Arkansas
Filing Company: Massachusetts Mutual Life Insurance Company State Tracking Number:
Company Tracking Number: AR MM513 SA
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.004 Partnership
Product Name: SignatureCare
Project Name/Number: /

Filing at a Glance

Company: Massachusetts Mutual Life Insurance Company

Product Name: SignatureCare SERFF Tr Num: LFCR-128535647 State: Arkansas
TOI: LTC03I Individual Long Term Care SERFF Status: Closed-Approved State Tr Num:
Sub-TOI: LTC03I.004 Partnership Co Tr Num: AR MM513 SA State Status: Approved-Closed
Filing Type: Form Reviewer(s): Donna Lambert
Authors: Smith Darlene, Scarlett Disposition Date: 07/03/2012
Nazari, Anoush Chngidakyan
Date Submitted: 07/02/2012 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: 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: 07/03/2012
State Status Changed: 07/03/2012
Deemer Date: Created By: Smith Darlene
Submitted By: Smith Darlene Corresponding Filing Tracking Number:
Filing Description:
July 2, 2012

Mr. Harris Shearer
Rate and Form Analyst
Arkansas Department of Insurance
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

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RE: MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY - NAIC # 65935
MM500-SAP-1-1-AR 0612 Part 1 Long Term Care Insurance Application
MM500-SAP-1-1-AR Part 1 (previously approved 06-07-11 – SERFF Filing # LFCR-127154973)
MM500-SA-2-AR 0612 Part 2 Supplemental Application For Long Term Care Insurance
MM500-SA-2-AR Part 2 (previously approved 12-10-07 – SERFF Filing # 125292639)

For Use With MM-500-P-1-AR 0612 et al (Approved 06-07-12)
SERFF # LFCR-127154973

Dear Mr. Shearer:

These application forms are being submitted for approval with updated form numbers and are being revised as follows:

Part 1: To accommodate removal of benefit features that will no longer be offered by the Company at this time. These include the Lifetime and 10 Year Benefit Periods, as well as the Discounted Renewals Premium Payment Option. All references to these benefit features have been removed from this form.

In addition the Company would like the ability to vary the offering of other benefit features without the need to re-file the application based upon the proposed variability. The specific benefit features for which we are seeking this option are for the Return of Premium on Death and the Full Return of Premium on Death Riders and the limited premium payment options – (10 year and Paid-Up at 65 Premium Payment Options). The Company would also like the ability to change the benefit periods available with the Shared Care Rider. In order to identify these variable benefit offerings within the form, we have bracketed the specific benefit features applicable. Revisions have also been made to Section 2 and Beneficiary Information has been added at the end of Section 3.

A Statement of Variability is being provided to serve as supporting documentation for the Company's intended handling of the variable benefit features to be offered.

Part 2: Text has been added to questions 2D and 2H, a question pertaining to family medical history has been added and revisions made to Sections 3 and 4. No bracketing is contained within this form as it does not include any variable text,

Other than those changes noted above, no other revisions have been made to these previously approved forms.

These forms are intended for use with the above referenced previously approved individual long term care forms and any up-dashed policy form numbers, within this policy series, subsequently approved for use. Proposed Applicants will be individually underwritten and issued individual policies in the same manner as a Proposed Applicant applying under the Company's standard application form.

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These application forms will be utilized in conjunction with the multi-life discount offered to employees of an approved employer group, as well as their family members, with a list billing arrangement for the employee. The employee's Covered Partner is also eligible to apply for a separate policy.

In order to expedite the application process Part I will be completed by the agent at the worksite. Part 2 will subsequently be completed via telephone and the Proposed Applicant will be required to sign this application upon delivery of their policy. Both applications will be included with the policy.

A Flesch certification is also included.

Concurrent with this filing, these forms are being filed in the Company's domiciliary state, Massachusetts.

Thank you for your assistance with this filing.

Sincerely,

Roscelia Pineda
Compliance Analyst
Phone: (800) 366-5463, extension 2357
Email: roscelia.pineda@LifeCareAssurance.com

State Narrative:

Company and Contact

Filing Contact Information

Roscelia Pineda, Product Support Quality Control Assistant
roscelia.pineda@lifecareassurance.com
P.O. Box 4243
818-867-2357 [Phone]
Woodland Hills, CA 91365-4243
818-867-2508 [FAX]

Filing Company Information

(This filing was made by a third party - LCA01)

Massachusetts Mutual Life Insurance Company CoCode: 65935 State of Domicile: Massachusetts
Long Term Care Administrative Office Group Code: 435 Company Type:
P.O. Box 4243 Group Name: State ID Number:

SERFF Tracking Number: LFCR-128535647 State: Arkansas
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TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.004 Partnership
Product Name: SignatureCare
Project Name/Number: /
Woodland Hills, CA 91365-4243 FEIN Number: 04-1590850
(818) 867-2450 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation: \$50.00 per form x 2 = \$100.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Massachusetts Mutual Life Insurance Company	\$100.00	07/02/2012	60605629

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	07/03/2012	07/03/2012

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Disposition

Disposition Date: 07/03/2012

Implementation Date:

Status: Approved

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	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	AR CERTIFICATION OF COMPLIANCE	Approved	Yes
Supporting Document	MM513 - TPA Filing Letter	Approved	Yes
Supporting Document	Statement of Variability	Approved	Yes
Form	LONG TERM CARE INSURANCE APPLICATION	Approved	Yes
Form	SUPPLEMENTAL APPLICATION FOR LONG TERM CARE INSURANCE	Approved	Yes

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Form Schedule

Lead Form Number: MM500-SAP-1-1-AR 0612

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 07/03/2012	MM500-SAP-1-1-AR 0612	Application/Enrollment Form	LONG TERM CARE INSURANCE APPLICATION	Revised	Replaced Form #: MM500-SAP-1-1-AR Previous Filing #: LFCR-127154973		MM500-SAP-1-1-AR 0612.pdf
Approved 07/03/2012	MM500-SA-2-AR 0612	Application/Enrollment Form	SUPPLEMENTAL APPLICATION FOR LONG TERM CARE INSURANCE	Revised	Replaced Form #: MM500-SA-2-AR Previous Filing #: LFCR-125292639		MM500-SA-2-AR 0612.pdf

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001
 Long Term Care Administrative Office
 P.O. Box 4243
 Woodland Hills, CA 91365-4243
 888.505.8952

LONG TERM CARE INSURANCE APPLICATION
 MM500-SAP-1-1-AR 0612 Part 1 (PLEASE PRINT)

Coverage Type Individual (1 Partner Applying) (Both Partners Applying)

SECTION 1: PROPOSED APPLICANT PERSONAL INFORMATION

Proposed Applicant 1		Proposed Applicant 2	
Name (First) (MI) (Last) <i>John Doe</i>	Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Name (First) (MI) (Last) <i>Jane Doe</i>	Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
Home Address (Street)(City) (State)(ZIP) <i>123 Main St., Anytown, ST 12345-1234</i>		Home Address (Street)(City) (State)(ZIP) <i>123 Main St., Anytown, ST 12345-1234</i>	
Billing Address (if different)		Billing Address (if different)	
Phone Home <i>(555) 555-1213</i> Work <i>(555) 555-1212</i> Best time to call? am or pm / home or work		Phone Home <i>(555) 555-1213</i> Work <i>(555) 555-1212</i> Best time to call? am or pm / home or work	
SS No. <i>123-45-6789</i>	Birth Date <i>1-1-57</i>	SS No. <i>234-56-7891</i>	Birth Date <i>1-1-62</i>
State of Birth <i>Anystate</i>		State of Birth <i>Anystate</i>	
Driver's License No. <i>X1234567</i>	License State <i>ST</i>	Driver's License No. <i>X2345678</i>	License State <i>ST</i>
Email (OPTIONAL) <i> johndoe@email.com</i>		Email (OPTIONAL) <i> janedoe@email.com</i>	
Occupation		Occupation	

SECTION 2: INSURABILITY INFORMATION

Proposed Applicant 1	Proposed Applicant 2
1. Do you currently need assistance with bathing, dressing, eating, taking medication, transferring from bed to chair or toileting? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. Do you currently need assistance with bathing, dressing, eating, taking medication, transferring from bed to chair or toileting? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. During the past 10 years, have you been medically diagnosed or treated for any of the following: AIDS or positive HIV status..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Alzheimer's Disease, Dementia..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cerebral Palsy..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cystic Fibrosis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hepatitis-Chronic..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Huntington's Chorea..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Insulin Dependent Diabetes <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Kidney Disease requiring dialysis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Liver Cirrhosis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Multiple Sclerosis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Myasthenia Gravis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Organic Brain Syndrome <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Paralysis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Parkinson's /Parkinsonism <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Schizophrenia..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Stroke, TIA..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Systemic Lupus <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	2. During the past 10 years, have you been medically diagnosed or treated for any of the following: AIDS or positive HIV status <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Alzheimer's Disease, Dementia <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cerebral Palsy..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cystic Fibrosis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hepatitis-Chronic..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Huntington's Chorea <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Insulin Dependent Diabetes <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Kidney Disease requiring dialysis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Liver Cirrhosis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Multiple Sclerosis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Myasthenia Gravis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Organic Brain Syndrome..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Paralysis..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Parkinson's /Parkinsonism <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Schizophrenia <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Stroke, TIA <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Systemic Lupus..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PLEASE NOTE: Before you continue with this application: If you answered YES to any of the questions under INSURABILITY INFORMATION above, we suggest you do not submit the application. If you answered NO to every question, please continue.

SECTION 2: INSURABILITY INFORMATION (continued)

Proposed Applicant 1

Proposed Applicant 2

<p>3. Have you consulted a Health Care Professional in the past 5 years? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", provide the Health Care Professional information. If "No", provide your current primary care physician or MD or other Health Care Professional who has the most complete records of your medical history. If you changed doctors in the past 12 months, please provide the previous doctor's information also (medical records may be ordered.)</p> <p>Name: <u>J. Doctor</u> Address: <u>145 Main St.</u> City, State ZIP: <u>145 Main St. Anytown ST 12345-1234</u> Phone: () Date/reason for last visit: <u>Check-up</u></p>	<p>3. Have you consulted a Health Care Professional in the past 5 years? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", provide the Health Care Professional information. If "No", provide your current primary care physician or MD or other Health Care Professional who has the most complete records of your medical history. If you changed doctors in the past 12 months, please provide the previous doctor's information also (medical records may be ordered.)</p> <p>Name: <u>J. Doctor</u> Address: <u>145 Main St.</u> City, State ZIP: <u>145 Main St. Anytown ST 12345-1234</u> Phone: () Date/reason for last visit: <u>Check-up</u></p>
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SECTION 3: COVERAGE AND PREMIUM INFORMATION

Proposed Applicant 1

Proposed Applicant 2

<p>* If a PARTNERSHIP POLICY is selected below and You are age 75 or younger, 5% Compound Inflation Protection or 3% Compound Inflation Protection must be selected and will be issued with Your Policy.</p>	
<p>1. Basic Plan Selection <input checked="" type="checkbox"/> Partnership Policy <input type="checkbox"/> Non-Partnership Policy <input type="checkbox"/> Facility Services Only <input checked="" type="checkbox"/> Comprehensive (Facility Services and Home & Community Based Services (HCBS)) <input type="checkbox"/> Comprehensive with HCBS Monthly Benefit Rider</p> <p>2. Daily Benefit Amount (DBA) \$ <u>100.00</u></p> <p>3. Benefit Period <input type="checkbox"/> 6 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> 4 Years <input checked="" type="checkbox"/> 3 Years <input type="checkbox"/> 2 Years]</p> <p>4. Elimination Period <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input checked="" type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days</p> <p>* Please refer to Partnership Program requirements above.</p> <p>5. Inflation Protection Rider (may select only one) <input checked="" type="checkbox"/> 5% Compound Inflation Protection <input type="checkbox"/> 3% Compound Inflation Protection</p> <p>[6. Return of Premium Riders (may select only one)] <input type="checkbox"/> Full Return of Premium on Death (available to age 65)] <input type="checkbox"/> Return of Premium on Death]</p> <p>[7. Elimination Period Riders (may select only one) (not available with Facility Services Only Plan) <input type="checkbox"/> HCBS Waiver of Elimination Period <input type="checkbox"/> Enhanced Elimination Period</p> <p>[8. Other Riders <input type="checkbox"/> Shortened Benefit Period Nonforfeiture <input type="checkbox"/> Restoration of Benefits</p> <p>[9. Covered Partner Riders (if applying as Covered Partners both must select any of the following riders) <input type="checkbox"/> Waiver of Premium for Covered Partner <input type="checkbox"/> Paid-Up Survivor [(available only w/Lifetime Premium Payment Option)] <input type="checkbox"/> Shared Care (Covered Partner coverage must be identical) [(available with 2 Year or 3 Year Benefit Period only)]</p>	<p>1. Basic Plan Selection <input checked="" type="checkbox"/> Partnership Policy <input type="checkbox"/> Non-Partnership Policy <input type="checkbox"/> Facility Services Only <input checked="" type="checkbox"/> Comprehensive (Facility Services and Home & Community Based Services (HCBS)) <input type="checkbox"/> Comprehensive with HCBS Monthly Benefit Rider</p> <p>2. Daily Benefit Amount (DBA) \$ <u>100.00</u></p> <p>3. Benefit Period <input type="checkbox"/> 6 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> 4 Years <input checked="" type="checkbox"/> 3 Years <input type="checkbox"/> 2 Years]</p> <p>4. Elimination Period <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input checked="" type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days</p> <p>* Please refer to Partnership Program requirements above.</p> <p>5. Inflation Protection Rider (may select only one) <input checked="" type="checkbox"/> 5% Compound Inflation Protection <input type="checkbox"/> 3% Compound Inflation Protection</p> <p>[6. Return of Premium Riders (may select only one)] <input type="checkbox"/> Full Return of Premium on Death (available to age 65)] <input type="checkbox"/> Return of Premium on Death]</p> <p>[7. Elimination Period Riders (may select only one) (not available with Facility Services Only Plan) <input type="checkbox"/> HCBS Waiver of Elimination Period <input type="checkbox"/> Enhanced Elimination Period</p> <p>[8. Other Riders <input type="checkbox"/> Shortened Benefit Period Nonforfeiture <input type="checkbox"/> Restoration of Benefits</p> <p>[9. Covered Partner Riders (if applying as Covered Partners both must select any of the following riders) <input type="checkbox"/> Waiver of Premium for Covered Partner <input type="checkbox"/> Paid-Up Survivor [(available only w/Lifetime Premium Payment Option)] <input type="checkbox"/> Shared Care (Covered Partner coverage must be identical) [(available with 2 Year or 3 Year Benefit Period only)]</p>

SECTION 3: COVERAGE AND PREMIUM INFORMATION (continued)

Proposed Applicant 1

Proposed Applicant 2

<p>* Please refer to Partnership Program requirements on page 2.</p> <p>[10].REJECTION OF INFLATION PROTECTION RIDER I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without the Inflation Protection Rider and I have chosen to reject the rider. Check Here <input type="checkbox"/></p> <p>[11].REJECTION OF NONFORFEITURE RIDER I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to reject the rider. Check Here <input checked="" type="checkbox"/></p>	<p>* Please refer to Partnership Program requirements on page 2.</p> <p>[10].REJECTION OF INFLATION PROTECTION RIDER I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without the Inflation Protection Rider and I have chosen to reject the rider. Check Here <input type="checkbox"/></p> <p>[11].REJECTION OF NONFORFEITURE RIDER I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to reject the rider. Check Here <input checked="" type="checkbox"/></p>
<p>[12].Discounts (see Application Instructions) <input checked="" type="checkbox"/> Covered Partner Discount (2 Proposed Applicants) <input type="checkbox"/> Partner Discount (1 Proposed Applicant) <input type="checkbox"/> Loyal Customer Discount Policy No. _____ <input type="checkbox"/> Employer Group Discount Group Name and Number _____</p> <p>[13].Premium Billing (may select only one) <input checked="" type="checkbox"/> List Bill <input checked="" type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> PAC</p> <p>[14].Premium Payment Options (may select only one) <input checked="" type="checkbox"/> Lifetime] [The following two options are not available under age 40] <input type="checkbox"/> 10-Year] <input type="checkbox"/> Paid-Up at Age 65 (available to age 55)]</p>	<p>[12].Discounts (see Application Instructions) <input checked="" type="checkbox"/> Covered Partner Discount (2 Proposed Applicants) <input type="checkbox"/> Partner Discount (1 Proposed Applicant) <input type="checkbox"/> Loyal Customer Discount Policy No. _____ <input type="checkbox"/> Employer Group Discount Group Name and Number _____</p> <p>[13].Premium Billing (may select only one) <input type="checkbox"/> Direct Bill <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> PAC <input checked="" type="checkbox"/> List Bill <input checked="" type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> PAC</p> <p>[14].Premium Payment Options (may select only one) <input checked="" type="checkbox"/> Lifetime] [The following two options are not available under age 40] <input type="checkbox"/> 10-Year] <input type="checkbox"/> Paid-Up at Age 65 (available to age 55)]</p>
<p>[15].Beneficiary Information (You may change the beneficiary at any time by notifying us in writing) Name: _____ Relationship: _____ Address: _____</p>	<p>[15].Beneficiary Information (You may change the beneficiary at any time by notifying us in writing) Name: _____ Relationship: _____ Address: _____</p>
<p>Special Request:</p>	<p>Special Request:</p>

SECTION 4: OTHER COVERAGE/REPLACEMENT INFORMATION

Proposed Applicant 1	Proposed Applicant 2
<p>1. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including health care service contract or health maintenance organization contract)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>2. Did you have another long term care insurance policy or certificate in force during the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If that policy lapsed, provide date of lapse _____</p> <p>3. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If you answered YES to any of the questions 1-3 above, provide full details below and complete the required replacement form(s):</p> <p>Question No. _____</p> <p>Company/Carrier: _____</p> <p>Type of Policy: _____ Issue Date: _____</p> <p>Daily Benefit Amount: \$ _____ Paid to Date: _____</p> <p>Question No. _____</p> <p>Company/Carrier: _____</p> <p>Type of Policy: _____ Issue Date: _____</p> <p>Daily Benefit Amount: \$ _____ Paid to Date: _____</p>	<p>1. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including health care service contract or health maintenance organization contract)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>2. Did you have another long term care insurance policy or certificate in force during the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If that policy lapsed, provide date of lapse _____</p> <p>3. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If you answered YES to any of the questions 1-3 above, provide full details below and complete the required replacement form(s):</p> <p>Question No. _____</p> <p>Company/Carrier: _____</p> <p>Type of Policy: _____ Issue Date: _____</p> <p>Daily Benefit Amount: \$ _____ Paid to Date: _____</p> <p>Question No. _____</p> <p>Company/Carrier: _____</p> <p>Type of Policy: _____ Issue Date: _____</p> <p>Daily Benefit Amount: \$ _____ Paid to Date: _____</p>

SECTION 5: PROTECTION AGAINST UNINTENTIONAL LAPSE

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

Proposed Applicant 1 (choose one):	Proposed Applicant 2 (choose one):
<p><input type="checkbox"/> I elect not to designate any person to receive such notice</p> <p><input type="checkbox"/> I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone: (_____) _____</p> <p>Relationship: _____</p>	<p><input type="checkbox"/> I elect not to designate any person to receive such notice</p> <p><input type="checkbox"/> I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone: (_____) _____</p> <p>Relationship: _____</p>

SECTION 6: COVERED PARTNER OR PARTNER DISCOUNT ELIGIBILITY

To be eligible for the Partner Discount you must be:

- married; or
- named in a valid certificate or license of civil union recognized by the state in which the Policy is issued; or
- living with someone for the past three consecutive years in a committed relationship as partners or as family members and sharing basic living expenses; and
 - are not married to each other or anyone else; and
 - not named in a certificate or license of civil union with each other or anyone else; and
 - if related, belong to the same family generation (e.g. siblings, cousins).

To be eligible for the Covered Partner Discount both applicants must meet the above criteria together.

I meet the criteria listed above. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	I meet the criteria listed above. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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SECTION 7: PROPOSED APPLICANT STATEMENT

NOTICE OF INSURANCE INFORMATION PRACTICES— To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. The information we obtain about you will be used by Massachusetts Mutual Life Insurance Company to determine eligibility for insurance and/or benefits under an existing policy and for other business purposes in connection with the insurance relationship. The information obtained may not be released to any person or organization except to reinsuring companies, any third party administrators designated by Massachusetts Mutual Life Insurance Company or other persons or organizations performing services in connection with your application, claim or as may be otherwise lawfully required or as you may further authorize. We will furnish a more detailed summary of our information practices upon request.

AGREEMENT — The answers given on Part 1 of this application and my subsequent responses on Part 2 of the application are complete and true and were correctly recorded to the best of my knowledge and belief. I understand that the Company will rely on my written answers to the questions in Parts 1 and 2 of this application and that if my answers are not complete and true, my policy may not be valid. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy.

I understand that the policy will become effective and in force on the Policy Effective Date only if the following occur: (1) Parts 1 and 2 of this application are approved by the Company; (2) a policy is issued during the lifetime of the Proposed Applicant; (3) the first premium is paid in full; and (4) there has been no change in the insurability of the Proposed Applicant since the date of completion of Parts 1 and 2 of the application and the date the policy is delivered.

ACKNOWLEDGMENT — I acknowledge receipt of an Outline of Coverage, NAIC Shopper's Guide, Potential Rate Increase Disclosure Form, and the Company's notices about the Medical Information Bureau, Inc. (MIB), the Fair Credit Reporting Act, the Company's privacy practices, and the HIPAA Notice of Privacy Practices.

AUTHORIZATION FOR DISCLOSURE, RECEIPT AND USE OF PERSONAL HEALTH INFORMATION —

Complete and submit F8186 with this application.

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.

This application (including Parts 1 and 2) will be part of the insurance policy for which I am applying. Further, if this application has been completed by two Proposed Applicants I understand that a copy of this application will be included in my Covered Partner's policy. "I", "you", and "your" mean the Proposed Applicant 1 and if applicable, Proposed Applicant 2 applying for coverage under this application.

CAUTION: If your answers on this application are incorrect or untrue, Massachusetts Mutual Life Insurance Company may have the right to deny benefits or rescind your policy.

Signed at Anytown, ST On 6-1-12
(City) (State) (Date)

Signature of Proposed Applicant 1: John Doe

Signature of Proposed Applicant 2: Jane Doe

SECTION 8: AGENT'S STATEMENT

8A: Rate Information

What Rate Class was proposed? Proposed Applicant 1: <input checked="" type="checkbox"/> Ultra Preferred <input type="checkbox"/> Select Preferred <input type="checkbox"/> Preferred Proposed Applicant 2: <input checked="" type="checkbox"/> Ultra Preferred <input type="checkbox"/> Select Preferred <input type="checkbox"/> Preferred	Did you consult the Field Underwriting Guide to determine rate class? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
---	--

8B: Other Coverage and Replacement Information

Is this part of a multi-Life case (i.e. family members, business partners, etc.)? Proposed Applicant 1: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Proposed Applicant 2: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Is there a Disability or Life Application being submitted concurrently with this Application? Proposed Applicant 1: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Proposed Applicant 2: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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Proposed Applicant 1	Proposed Applicant 2
To the best of your knowledge, is the insurance applied for intended to replace any long term care, medical or health insurance in force with this or any company? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No List any other health insurance policies that you have sold to the Proposed Applicant(s): _____ Which of the policies listed above are still in force, if any? _____ Which of the policies listed above sold in the past 5 years are no longer in force, if any? _____	To the best of your knowledge, is the insurance applied for intended to replace any long term care, medical or health insurance in force with this or any company? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No List any other health insurance policies that you have sold to the Proposed Applicant(s): _____ Which of the policies listed above are still in force, if any? _____ Which of the policies listed above sold in the past 5 years are no longer in force, if any? _____

8C: Forms Delivery and Signatures

Did you provide Proposed Applicant(s) with all required notices? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (if "No", provide details)	Did you ask the Proposed Applicant(s) all the questions face to face and witness their signature(s)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (if "No", provide details)
--	--

I certify that the answers to the questions provided by the Proposed Applicant(s) were fully and accurately recorded in the application, and that the questions in the Agent's Statement have been answered accurately. I have reviewed the current health insurance coverage of the Proposed Applicant(s) and find that the coverage of the type and amount applied for is appropriate for the needs of the Proposed Applicant(s). Further, if this is a replacement, I have reviewed the current health insurance coverage of the Proposed Applicant(s) and find that this replacement is appropriate for the needs of the Proposed Applicant(s).

Licensed Agent's Name (please print) John Q. Porter Ident. Code 1234

Licensed Agent's Signature John Q. Porter Date 6-1-12

Agent's Phone (555) 555-1515

Agent's Fax _____ Agency Number _____

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001

Long Term Care Administrative Office

P.O. Box 4243

Woodland Hills, CA 91365-4243

888.505.8952

**SUPPLEMENTAL APPLICATION FOR
LONG TERM CARE INSURANCE**

MM500-SA-2-AR 0612 Part 2 (PLEASE PRINT)

Policy Number:	Policy Number:
----------------	----------------

Section 1: Proposed Applicant(s) Information

Proposed Applicant 1

Name:			
_____	_____	_____	_____
First	Middle Initial	Last	
Social Security Number: _____			
Date of Birth: _____			
Month	Day	Year	
Insuring Age (as of nearest birthday): _____			

Proposed Applicant 2

Name:			
_____	_____	_____	_____
First	Middle Initial	Last	
Social Security Number: _____			
Date of Birth: _____			
Month	Day	Year	
Insuring Age (as of nearest birthday): _____			

Section 2: Medical Information

Proposed Applicant 1

2A. Are you currently receiving Social Security Disability or Medicaid (not Medicare)?
 yes no

2B. Do you currently use or have you used in the past 12 months a walker, crutches, braces, wheelchair, motorized cart, hospital bed, oxygen, or cane?
 yes no

2C. Within the past 12 months have you been advised to have any special testing or surgery that has not yet been performed or are you aware of any symptoms or complaints for which you plan to seek medical advice or treatment?
 yes no

2D. Within the past 12 months, have you been hospitalized, received rehabilitative services including physical therapy, occupational therapy, home care or been confined to a nursing home or assisted living facility?
 yes no

2E. Within the past 12 months, have you received disability income or workers' compensation or any other state disability?
 yes no

2F. Within the past 5 years, have you had or been issued a handicap tag?
 yes no

2G. Within the past 5 years, have you been declined for long term care insurance?
 yes no

Proposed Applicant 2

2A. Are you currently receiving Social Security Disability or Medicaid (not Medicare)?
 yes no

2B. Do you currently use or have you used in the past 12 months a walker, crutches, braces, wheelchair, motorized cart, hospital bed, oxygen, or cane?
 yes no

2C. Within the past 12 months have you been advised to have any special testing or surgery that has not yet been performed or are you aware of any symptoms or complaints for which you plan to seek medical advice or treatment?
 yes no

2D. Within the past 12 months, have you been hospitalized, received rehabilitative services including physical therapy, occupational therapy, home care or been confined to a nursing home or assisted living facility?
 yes no

2E. Within the past 12 months, have you received disability income or workers' compensation or any other state disability?
 yes no

2F. Within the past 5 years, have you had or been issued a handicap tag?
 yes no

2G. Within the past 5 years, have you been declined for long term care insurance?
 yes no

Section 2: Medical Information (continued)

Proposed Applicant 1

Proposed Applicant 2

2H. During the past 10 years, have you received medical advice, consultation, or treatment for the following diseases, disorders or conditions? If YES, please check appropriate boxes for each Proposed Applicant and provide additional information under the DETAILS section.

- yes no Alcoholism, Drug Dependency
- yes no Blood or Endocrine (Glandular) Disorder
- yes no High Blood Pressure
- yes no Diabetes
- yes no Brain, Spinal Cord, or Neurological Disease
- yes no Cancer (Internal)
- yes no Heart, Circulatory, Vascular Disorder
- yes no Kidney, Bladder, or Prostate Condition
- yes no Musculoskeletal (bone or joint) or Skin Disorder
- yes no Progressive Eye Condition
- yes no Psychiatric, Mental Disorder, or Depression
- yes no Respiratory or Lung Disorder
- yes no Stomach, Esophagus, Intestine, Liver, or Pancreas Condition

2H. During the past 10 years, have you received medical advice, consultation, or treatment for the following diseases, disorders or conditions? If YES, please check appropriate boxes for each Proposed Applicant and provide additional information under the DETAILS section.

- yes no Alcoholism, Drug Dependency
- yes no Blood or Endocrine (Glandular) Disorder
- yes no High Blood Pressure
- yes no Diabetes
- yes no Brain, Spinal Cord, or Neurological Disease
- yes no Cancer (Internal)
- yes no Heart, Circulatory, Vascular Disorder
- yes no Kidney, Bladder, or Prostate Condition
- yes no Musculoskeletal (bone or joint) or Skin Disorder
- yes no Progressive Eye Condition
- yes no Psychiatric, Mental Disorder, or Depression
- yes no Respiratory or Lung Disorder
- yes no Stomach, Esophagus, Intestine, Liver, or Pancreas Condition

2I. Does/Did any family members (mother, father, siblings) have any of the following:

- Alzheimer's disease ALS (Lou Gehrig's Disease)
- Dementia Disease)
- Heart Disease Parkinson's disease
- Polycystic Kidney Disease Huntington's disease
- Stroke

2I. Does/Did any family members (mother, father, siblings) have any of the following:

- Alzheimer's disease.. ALS (Lou Gehrig's Disease).....
- Dementia..... Disease).....
- Heart Disease Parkinson's disease.....
- Polycystic Kidney Disease Huntington's disease
- Stroke

2J. What is your current Weight: 180 Height: 6' 0"

2K. Any changes in weight of 15 pounds or more within past 12 months?

- yes no

If YES answer above indicate gain or loss and reason:

2L. Have you smoked cigarettes in past 12 months:

- yes no

If quit, date last smoked? _____

2J. What is your current Weight: 130 Height: 5' 5"

2K. Any changes in weight of 15 pounds or more within past 12 months?

- yes no

If YES answer above indicate gain or loss and reason:

2L. Have you smoked cigarettes in past 12 months:

- yes no

If quit, date last smoked? _____

Section 3: LIST ALL MEDICATION(S)

Proposed Applicant 1

Proposed Applicant 2

List all medications taken or that have been prescribed to you at any time during the past 2 years and include dosage/frequency/reason/prescribing Health Care Professional.

List all medications taken or that have been prescribed to you at any time during the past 2 years and include dosage/frequency/reason/prescribing Health Care Professional.

Section 4: DETAILS

Indicate question number, include diagnosis or disorder, dates, names and addresses of all Health Care Professionals and medical facilities.

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Section 5: Proposed Applicant Statements

AGREEMENT — The answers given on Part 1 of this application and my subsequent responses on Part 2 of the application are complete and true and were correctly recorded to the best of my knowledge and belief. I understand that the Company will rely on my written answers to the questions in Parts 1 and 2 of this application and that if my answers are not complete and true, my policy may not be valid. I understand that the agent cannot determine eligibility for or alter the terms of the proposed policy.

The following applies individually and separately to each Proposed Applicant: I understand that the insurance applied for will become effective and in force on the Policy Effective Date only if all of the following occur: (1) Parts 1 and 2 of this application are approved by the Company; (2) a policy is issued during the lifetime of the Proposed Applicant; (3) the full first premium is paid; and (4) there has been no change in the insurability of the Proposed Applicant since the date of completion of Parts 1 and 2 of the application and the date the policy is delivered.

This application (including Parts 1 and 2) will be part of the insurance policy for which I am applying. Further, if this application has been completed by two Proposed Applicants I understand that a copy of this application will be included in my Covered Partner's policy.

"I", "you", and "your" mean the Proposed Applicant 1 and if applicable, Proposed Applicant 2 applying for coverage under this application.

CAUTION: If your answers on this application are incorrect or untrue, Massachusetts Mutual Life Insurance Company may have the right to deny benefits or rescind your policy.

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.

Signature of Proposed Applicant 1:	<u>John Doe</u>	<u>6-1-12</u> Date
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Signature of Proposed Applicant 2:	<u>Jane Doe</u>	<u>6-1-12</u> Date
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SERFF Tracking Number: LFCR-128535647 State: Arkansas
 Filing Company: Massachusetts Mutual Life Insurance Company State Tracking Number:
 Company Tracking Number: AR MM513 SA
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.004 Partnership
 Product Name: SignatureCare
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: MM513 - AR Flesch Score.pdf		
Bypassed - Item: Application Bypass Reason: Application attached in form schedule for review Comments:		
Bypassed - Item: Health - Actuarial Justification Bypass Reason: N/A Comments:		
Bypassed - Item: Outline of Coverage Bypass Reason: N/A Comments:		
Satisfied - Item: AR CERTIFICATION OF COMPLIANCE Comments: Attachment: AR CERTIFICATION OF COMPLIANCE.pdf	Approved	07/03/2012

SERFF Tracking Number: LFCR-128535647 State: Arkansas
Filing Company: Massachusetts Mutual Life Insurance Company State Tracking Number:
Company Tracking Number: AR MM513 SA
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.004 Partnership
Product Name: SignatureCare
Project Name/Number: /

	Item Status:	Status Date:
Satisfied - Item: MM513 - TPA Filing Letter	Approved	07/03/2012
Comments:		
Attachment: MM513 - TPA Filing Letter.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability	Approved	07/03/2012
Comments:		
Attachment: Statement of Variability.pdf		

FLESCH SCALE CERTIFICATE

FORM NUMBERS:

MM500-SAP-1-1-AR 0612 Long Term Care Insurance Application (Part 1)

MM500-SA-2-AR 0612 Supplemental Application For Long Term Care Insurance (Part 2)

NUMBER OF WORDS: (**X**) 10,000 or less. Entire form was analyzed.
() More than 10,000 words. 200 word samples per page
were analyzed.

Massachusetts Mutual Life Insurance Company certifies that a Flesch Scale Readability test has been applied to the above forms. The applications have been Flesch-scored as part of the policy. The score for the forms are as follows:

MM500-SAP-1-1-AR 0612.....51

MM500-SA-2-AR 0612.....51



Paul M. Gribbons
Vice President, DI/LTCi, Product Development
July 2, 2012

CERTIFICATION OF COMPLIANCE

Insurer: Massachusetts Mutual Life Insurance Company

The company has reviewed the enclosed policy form(s) and certified that they comply with the provision of Rule and Regulation 13 as well as all applicable requirements of the Arkansas Department of Insurance.

Signature:   Digitally signed by Roscelia Pineda
DN: cn=Roscelia Pineda, c=US
Date: 2012.07.02 08:28:27 -07'00'

Name: Roscelia Pineda

Title: Compliance Analyst

Date: July 2, 2012



August 23, 2011

Eileen Mangold, Vice President
Product Filing and Regulatory Compliance
LifeCare Assurance Company
21600 Oxnard Street, Suite 1500
Woodland Hills, CA 91367

Re: MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY – NAIC # 65935

Dear Eileen:

This letter will serve as the Company's authorization for LifeCare Assurance Company (Long Term Care Administrators), to file Long Term Care products on behalf of Massachusetts Mutual Life Insurance Company. This authorizes LifeCare to file on our behalf from today through August 1, 2012.

Sincerely,

A handwritten signature in black ink, appearing to read 'DJJ', with a long horizontal line extending to the right.

Douglas J. Jangraw, Corporate Vice President & Actuary
Disability Income and Long Term Care
E-mail: DJangraw@MassMutual.com Direct Line: 1-860-562-3800

CC: Paul Gribbons, Vice President Long Term Care Insurance

Massachusetts Mutual Life Insurance Company
Long Term Care Administrative Office
21600 Oxnard Street, Suite 1500 • Mailing Address: Post Office Box 4243
Woodland Hills, CA 91365-4243
(888) 505-8952 • Fax (818) 887-4595

STATEMENT OF VARIABILITY

Long Term Care Insurance Application Part 1

For Filed Form Number Refer to attached Form Filing Cover Letter

Brackets [] indicate items that will be as shown or omitted

As stated in the cover letter the Company would like the ability to vary the offering of specific benefit features.

Form - Long Term Care Insurance Application (Part 1)

Page 2: Coverage and Premium Information

Benefit Period – 6 Years, 5 Years, 4 Years, 3 Years 2 Years – availability of all or several of these Benefit Periods

Return of Premium Riders – Full Return of Premium on Death, Return of Premium on Death – availability of both or neither of these riders

Shared Care Rider – availability with specific Benefit Periods

Page 3: Coverage and Premium Information (continued)

Premium Payment Options – availability of both, either, or neither of the limited pay options, if Lifetime is the only option offered, this selection will not be shown