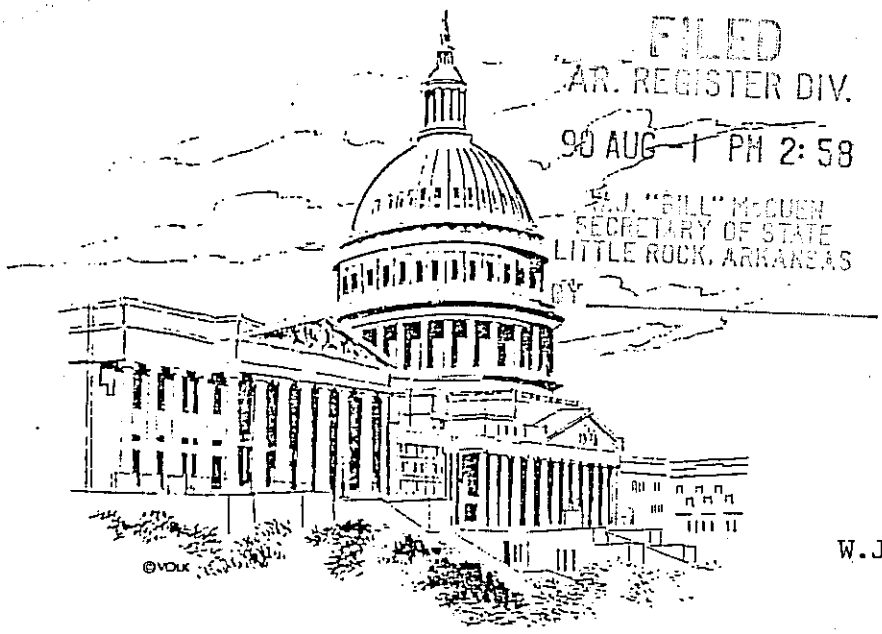

ARKANSAS REGISTER

Transmittal Sheet

W.J. "Bill" McCuen, SECRETARY OF STATE
STATE CAPITOL
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For Office Use Only: Effective Date 8-21-90 Code Number 064.00.90--005

Name of Agency Arkansas Insurance Department

Department Legal Division

Contact Person Cindy M. English Telephone 371-1811

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CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance With Act 434 of 1967 As Amended.

Ron Taylor
SIGNATURE

Insurance Commissioner
TITLE

7-27-90
DATE

054.00.90--005

RULE AND REGULATION 27

MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT POLICIES

TABLES OF CONTENTS

Section 1. Purpose

The purpose of this regulation is to provide reasonable standardization and simplification of terms and coverages of Medicare Supplement Policies in order to facilitate public understanding and comparison of such policies and to eliminate provisions contained in such policies or contracts which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims and to provide for full disclosures in the sale of such coverages to persons eligible for Medicare by reason of age.

Section 2. Authority

This rule is issued pursuant to the authority vested in the Commissioner under Ark. Code Ann. §23-61-108, §23-66-201 through §23-66-214, §§23-66-301 et seq., §23-79-109, §23-79-110, §23-85-105, §23-86-105, §23-74-122, §23-75-111, §23-76-125 and §§25-15-202, et seq., and Public Law 101-234.

Section 3. Applicability and Scope

Except as otherwise specifically provided in Sections 10 and 11, this regulation shall apply to:

A. All Medicare Supplement policies and subscriber contracts delivered or issued for delivery in this State on or after the effective date hereof; and

B. All certificates issued under group Medicare Supplement policies or subscriber contracts, which certificates have been delivered or issued for delivery in this state.

C. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Section 4. Definitions

For purposes of this Regulation:

A. "Applicant" means:

(1) in the case of an individual Medicare policy or contract, the person who seeks to contract for insurance benefits, and

(2) in the case of a group Medicare Supplement policy or contract, the proposed certificate-holder or enrollee.

B. "Certificate" means any certificate of insurance, contract or evidence of coverage issued by an insurer, fraternal benefit society, hospital/medical service corporation, or health maintenance organization to a resident of this State.

C. "Policy" means any individual or group policy, contract or subscriber agreement issued by an insurer, fraternal benefit society, hospital/medical service corporation or health maintenance organization to a resident or group in this State.

D. "Medicare Supplement Policy" means a group or individual policy of disability insurance or a subscriber contract of a hospital/medical service corporation or a contract of a health maintenance organization or a certificate of a fraternal benefit society which is advertised, marketed or designed as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.

Section 5. Policy Definitions and Terms

No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare Supplement policy unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

A. "Accident", "Accidental Injury", or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.

(2) Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.
NOTE: The first party coverage which was prescribed for use in automobile liability policies issued in Arkansas effective July 1, 1974 is not a motor vehicle no-fault plan under which benefits may be excluded under this section.

B. "Benefit Period" or "Medicare Benefit Period" shall not be defined as more restrictive than as that defined in the Medicare program.

C. "Convalescent Nursing Home", "Extended Care Facility", or "Skilled Nursing Facility" shall be defined in relation to its status, facilities and available services. Rehabilitory facilities licensed as hospitals in Arkansas shall be included in the definition of convalescent nursing homes for the purpose of this rule.

(1) A definition of such home or facility shall not be more restrictive than one requiring that it:

(a) be operated pursuant to law;

(b) be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

(c) be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(d) provide continuous twenty-four (24) hours a day nursing service or under the supervision of a registered graduate professional nurse (R.N.); and

(e) maintains a daily medical record of each patient.

(2) The definition of such home or facility may provide that such term not be inclusive of:

(a) any home, facility or part thereof used primarily for rest;

(b) a home or facility for the aged or for the care of drug addicts or alcoholics; or

(c) a home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

D. "Health Care Expenses" means expenses of health maintenance organizations associated with the delivery of health care services which are analogous to incurred losses of insurers.

Such expenses shall not include:

(1) home office and overhead costs;

(2) advertising costs;

(3) commissions and other acquisition costs;

(4) taxes;

(5) capital costs;

(6) administrative costs; or

(7) claims processing costs.

E. "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

(1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(a) be an institution operated pursuant to law; and

(b) be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and

(c) provide twenty-four (24) hour nursing service by or under the supervision of registered graduate professional nurses.

(2) The definition of the term "hospital" may state that such term shall not be inclusive of:

(a) convalescent homes, convalescent, rest, or nursing facilities; or

(b) facilities primarily affording custodial, educational or rehabilitory care; or

(c) facilities for the aged, drug addicts or alcoholics; or

(d) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis when a legal liability exists for charges made to the individual for such services.

F. "Medicare" shall be defined in the policy. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965 as Then Constituted or Later Amended", or "Title I, Part 1 of Public Law 89-97 as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

G. "Medicare Eligible Expenses" shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for

Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to Medicare claims.

H. "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

I. "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse", "trained nurse", "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualified under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

J. "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician". The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

K. "Sickness" shall not be defined to be more restrictive than the following:

"Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force".

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Section 6. Prohibited Policy Provisions

A. No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare Supplement policy as defined in Section 4 of this Regulation, if such policy or certificate limits or excludes coverage by type of illness, accident, treatment or medical condition, except as follows:

(1) foot care in connection with corns, callouses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

(2) mental or emotional disorders, alcoholism and drug addiction;

(3) illness, treatment or medical condition arising out of:

(a) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary thereto;

(b) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(c) aviation;

(4) cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;

(5) care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effect thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column;

(6) treatment provided in a governmental hospital; benefits provided under Medicare or other governmental programs (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(7) dental care or treatment;

(8) eye glasses, hearing aids and examination for the prescription of fitting thereof;

(9) rest cures, custodial care, transportation and routine physical examinations;

(10) territorial limitations, outside the United States;

provided, however, supplemental policies may not contain, when issued, limitations or exclusions of the type enumerated in subsections (1), (5), (9), or (10) above that are more restrictive than those of Medicare. Medicare Supplement policies may exclude coverage for any expense to the extent of any benefit available to the insured under Medicare.

B. No Medicare Supplement policy may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare Supplement policy or certificate may include a policy fee or any other similar charge. Applicants cannot be required to pay any fee other than the approved premium.

D. The terms "Medicare Supplement", "Medigap" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

E. No Medicare Supplement insurance policy, contract or certificate in force in this State shall contain benefits which duplicate benefits provided by Medicare.

Section 7. Benefit Conversion Requirements

A. Effective January 1, 1990, no Medicare Supplement insurance policy, contract or certificate in force in this State shall contain benefits which duplicate benefits provided by Medicare.

B. Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

C. For Medicare Supplement policies subject to the minimum standards adopted by the states pursuant to Medicare Catastrophic Coverage Act of 1988, the minimum benefits shall be:

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage for either, all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for

hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with federal regulations or already paid for under Part B;

(6) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$75];

(7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

Section 8. Minimum Benefit Standards

No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare Supplement policy which does not meet the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

A. General Standards.

The following standards apply to Medicare Supplement policies and are in addition to all other requirements of this regulation:

(1) A Medicare Supplement policy may not deny a claim for losses incurred more than six (6) months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage;

(2) A Medicare Supplement policy may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;

(3) A Medicare Supplement policy shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes. Any Federal budget reduction measure that reduces

Medicare payments shall not be considered a change in the Medicare copayment percentage factor;

(4) A "noncancellable", "guaranteed renewable", or "noncancellable and guaranteed renewable" Medicare Supplement policy shall not:

(a) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health; and

(5) (a) Except as authorized by the Commissioner of this State, an insurer shall neither cancel nor nonrenew a Medicare Supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation;

(b) If a group Medicare Supplement insurance policy is terminated by the group policyholder and not replaced as provided in Subsection (5)(d), the insurer shall offer certificate-holders an individual Medicare Supplement policy. The insurer shall offer the certificate-holder at least the following choices:

(1) an individual Medicare Supplement policy which provides for continuation of the benefits contained in the group policy; and

(2) an individual Medicare Supplement policy which provides only such benefits as are required to meet the minimum standards.

(c) If membership in a group is terminated, the insurer shall:

(1) offer the certificate-holder such conversion opportunities as are described in Paragraph (b); or

(2) at the option of the group policyholder, offer the certificate-holder continuation of coverage under the group policy.

(d) If a group Medicare Supplement policy is replaced by another group Medicare Supplement policy purchased by the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced;

(6) Termination of a Medicare Supplement policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period while the policy was in force may be predicated upon the continuous total disability of the insured limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

B. Minimum Benefit Standards.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(6) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$75] maximum benefit;

(7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

C. Medicare Eligible Expenses.

Medicare eligible expenses shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare eligible

expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to Medicare claims.

Section 9. Standards for Claims Payments

A. Every entity providing Medicare Supplement policies or contracts shall comply with all provisions of Section 4081 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203).

B. Compliance with the requirements set forth in Subsection A above must be certified on the Medicare Supplement insurance experience reporting form.

Section 10. Loss Ratio Standards

Medicare Supplement policies shall return to policyholders in the form of aggregate benefits under the policy, for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices:

A. At least 75 percent of the aggregate amount of premiums earned in the case of group policies, and

B. At least 60 percent of the aggregate amount of premiums earned in the case of individual policies.

All filings of rates and rating schedules shall demonstrate that actual and expected losses in relation to premiums comply with the requirements of this section.

C. Every entity providing Medicare Supplement policies in this State shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by number of years of policy duration demonstrating that it is in compliance with the foregoing applicable loss ratio standards and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principles and experience.

For the purposes of this section, policy forms shall be deemed to comply with the loss ratio standard if: (i) for the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for three years or more is greater than or equal to the applicable percentages contained in this section; and (ii) the expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of this section. An expected third-year loss ratio which is greater than or equal to the

applicable percentage shall be demonstrated for policies or certificates in force less than three years.

D. As soon as practicable, prior to the effective date of Medicare benefit changes every insurer, health care service plan or other entity providing Medicare Supplement insurance or contracts in this State shall file with the Commissioner, in accordance with the applicable filing procedures of this State:

(For purposes of this section, Medicare Supplement Policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.)

(1) (a) Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Such supporting documents as necessary to justify the adjustment shall accompany the filing; and

(b) Every insurer, health care service plan or other entity providing Medicare Supplement insurance or benefits to a resident of this State shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or contract as will conform with minimum loss ratio standards for Medicare Supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the insurer, health care service plan or other entity for such Medicare Supplement insurance policies or contracts. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date;

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare Supplement insurance modifications necessary to eliminate benefit duplications with Medicare. Any such riders, endorsements or policy forms shall provide a clear description of the Medicare Supplement benefits provided by policy or contract.

Section 11. Filing Requirements for Out-Of-State Group Policies

Every insurer providing group Medicare Supplement insurance benefits to a resident of this State shall file a copy of the master policy and any certificate used in this State in accordance with the filing requirements and procedures applicable to group Medicare Supplement policies issued in this State. Provided, however, that no insurer shall be required to make a filing earlier than 30 days after insurance was provided to a resident of this State under a master policy issued for delivery outside this State.

Section 12. Permitted Compensation Arrangements

A. An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare Supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for at least three years beyond the anniversary of the date of issuance.

C. No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies or certificates if an existing policy or certificate is replaced, unless the coverage benefits of the new policy or certificate are clearly and substantially greater than the benefits under the replaced policy or certificate.

D. "Compensation" includes pecuniary or non-pecuniary remuneration of of any kind relating to the sale or renewal of the policy or certificate including but not limited to commissions, bonuses, gifts, prizes, awards, finders fees, and any and all other fees.

Section 13. Required Disclosure Provisions

A. General Rules

(1) Medicare Supplement policies shall include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. Such provisions shall be appropriately captioned and shall appear on the first page of the policy.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured, or exercises a specifically reserved right under a Medicare policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits; all riders or endorsements added to a Medicare Supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare Supplement insurance policies, or if the increased benefits or coverage is

required by law or this regulation. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(3) A Medicare Supplement policy which provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(4) If a Medicare Supplement policy contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations".

(5) Medicare Supplement policies or certificates shall have a notice printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6) Insurers issuing disability policies, certificates or subscriber contracts which provide hospital or medical expense coverage on expense incurred or indemnity basis, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide to all applicants a Medicare Supplement "buyer's guide" in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration. Delivery of the "buyer's guide" shall be made whether or not such policies, certificates or subscriber contracts are advertised, solicited or issued as Medicare Supplement policies as defined in this regulation. Except in the case of direct response insurers, delivery of the "buyers guide" shall be made to the applicant at the time application and acknowledgement of receipt of the "buyer's guide" shall be obtained by the insurer. Direct response insurers shall deliver the "buyer's guide" to the applicant upon request but not later than at the time the policy is delivered.

B. Notice Requirements.

(1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare Supplement insurance or benefits to a resident of this State shall notify its policyholders, contract holders and certificate-holders of modifications it

has made to Medicare Supplement insurance policies or contracts in the format set forth in Appendix A;

(a) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare Supplement insurance policy or contract, and

(b) Inform each covered person as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) Such notices shall not contain or be accompanied by any solicitation.

C. Outline of Coverage Requirements for Medicare Supplement Policies.

(1) Insurers issuing Medicare Supplement policies or certificates for delivery in this State shall provide an outline of coverage to all applicants at the time application is made and, except for direct response policies, shall obtain an acknowledgement of receipt of such outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare Supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage provided to applicants pursuant to paragraphs (1) and (2) shall include at a minimum, the information prescribed in Appendix B. All outlines of coverage shall be no less than ten (10) point type, ten leaded.

D. Notice Regarding Policies or Subscriber Contracts Which Are Not Medicare Supplement Policies.

Any accident and sickness policy or certificate, other than a Medicare Supplement policy; or a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. §1395 et seq.), disability income policy, basic, catastrophic, or major medical expense policy, single premium

nonrenewable policy or other policy identified in Section 3B of this regulation, issued for delivery in this State to persons eligible for Medicare by reason of age shall notify insureds under the policy or certificate that the policy or certificate is not a Medicare Supplement policy. Such notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or certificate, subscriber contract, or if no outline of coverage is delivered, to the first page of the policy, certificate or subscriber contract delivered to insureds. Such notice shall be no less than twelve (12) point type and shall contain the following language:

"THIS [POLICY, CERTIFICATE OR SUBSCRIBER CONTRACT] IS NOT A MEDICARE SUPPLEMENT [POLICY, CERTIFICATE OR CONTRACT]. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."

Section 14. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether as of the date of the application, the applicant has another Medicare Supplement insurance policy in force or whether a Medicare Supplement policy or certificate is intended to replace any other disability policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent except where the coverage is sold without an agent, containing such questions may be used.

(1) Do you have another Medicare Supplement insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(2) Did you have another Medicare Supplement policy or certificate in force during the last twelve (12) months?

(a) If so, with which company?

(b) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid?

(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

B. Agents shall list any other health insurance policy they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years which are no longer in force.

C. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare Supplement policy or certificate, a comparison of benefits form and notice regarding replacement of disability coverage. The replacement/comparison/notice (hereinafter referred to as "notice") shall be signed by the applicant and the agent, except where the coverage is sold without an agent. One copy of the "notice" shall be left with the applicant. One copy shall be attached to the application and made a part of the policy. A direct response insurer shall deliver to the applicant at the time of the issuance of the policy the "notice" regarding replacement of disability coverage: said "notice" is also to be a part of the policy.

D. The notice required by Subsection C above for an insurer, other than a direct response insurer, shall be provided in substantially the format found in Appendix C.

E. The notice required by Subsection C above for a direct response insurer is found in Appendix D.

Section 15. Filing Requirements for Advertising

Every insurer, health care service plan or other entity providing Medicare Supplement insurance or benefits in this State shall provide a copy of any Medicare Supplement advertisement intended for use in this State whether through written, radio or television medium to the Commissioner of Insurance of this State for review and approval by the Commissioner.

Section 16. Standards for Marketing

A. Every insurer, health care service plan or other entity marketing Medicare Supplement insurance coverage in this State, directly or through its producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with medical care incurred by the buyer

during the period of coverage. The buyer is advised to carefully review all policy limitations."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare Supplement insurance already has disability insurance and the types and amounts of any such insurance.

(5) Every insurer or entity marketing Medicare Supplement insurance shall establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in Ark. Code Ann. §§23-66-201, et seq., the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer. Conviction of twisting is a class D felony pursuant to Ark. Code Ann. §23-66-306.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

Section 17. Appropriateness of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare Supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of Medicare Supplement coverage which will provide an individual more than one Medicare Supplement policy or certificate is prohibited; provided, however, that additional Medicare Supplement coverage may be sold if, when combined with that individual's health coverage already in force, it would insure no more than 100% of the individual's actual medical expenses covered under the combined policies.

Section 18. Reporting of Multiple Policies

A. Annually, On or before March 1, every insurer or other entity providing Medicare Supplement insurance coverage in this State shall report the following information for every individual resident of this State for which the insurer or entity has in force more than one Medicare Supplement insurance policy or certificate:

(1) Policy and certificate number, and

(2) Date of issuance.

B. The items set forth above must be grouped by individual policyholder.

C. The format as prescribed in Appendix E should be used for this report.

Section 19. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

If a Medicare Supplement policy or certificate replaces another Medicare Supplement policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare Supplement policy for similar benefits to the extent such time was spent under the original policy.

Section 20. Severability

Any section or provision of this rule held by a court to be invalid or unconstitutional will not affect the validity of any other section or provision.

Section 21. Effective Date

This regulation shall be effective on September 1, 1990.

Ron Taylor

RON TAYLOR
INSURANCE COMMISSIONER

7-27-90

DATE

APPENDIX A

[COMPANY NAME]

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE - 1990

THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!

[A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.]

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In 1989 Medicare Pays Per Calendar Year	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990 Your Coverage Will Pay
MEDICARE PART A SERVICES AND SUPPLIES				
Inpatient Hospital Services	Unlimited number of hospital days after $560 deductible	All but $592 for first 60 days/ benefit period		
Semi-Private Room & Board		All but $148 a day for 61st-90th days/benefit period		
Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room		All but $296 a day for 91st-150th days (if individual chooses to use 60 nonrenewable Lifetime reserve days)		
BLOOD	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period		
SKILLED NURSING FACILITY CARE	There is no prior confinement requirement for this benefit	100% of costs for 1st 20 days (after a 3 day prior hospital confinement)/benefit period		
	First 8 days - all but $25.50 a day	All but $74.00 a day for 21st-100th days/ benefit period		

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In 1989 Medicare Pays Per Calendar Year	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990 Your Coverage Will Pay
	9th through 150th day - 100% of costs Beyond 150 days - Nothing	Beyond 100 days - Nothing/benefit period		
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after $75 deductible)	80% of allowable charges (after $75 deductible/ calendar year)		
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immuno-suppressive drugs during the first year following a covered transplant (after $75 deductible/ calendar year)	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $75 deductible/calendar year)		
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after $75 deductible/calendar year)	80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after $75 deductible/calendar year)		

[Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.]

[Describe any coverage provisions changing due to Medicare modifications.]

[Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY [COMPANY] ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT [POLICY] CONTACT:

[COMPANY OR FOR ALL INDIVIDUAL POLICY - NAME OF AGENT] [ADDRESS/PHONE NUMBER]

APPENDIX B

[COMPANY NAME]
OUTLINE OF MEDICARE
SUPPLEMENT COVERAGE
AND PREMIUM INFORMATION

Use this outline to compare benefits and premiums among policies:

1. Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provision will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. Medicare Supplement Coverage - Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physicians' charges, subject to any deductibles and copayment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine [delete if such coverage is provided].

3. A. (for agents):

   Neither [insert company's name] nor its agents are connected with Medicare.

   B. (for direct responses):

   [insert company's name] is not connected with Medicare.

4. A brief summary of the major medical benefit gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, (and indexed copayments or deductibles, as appropriate) provided by the Medicare Supplement coverage in the following order:

NOTE: Medicare does not always pay the usual and customary provider fees but only pays what Medicare considers allowable and recognized charges. A further explanation of this appears in the "Guide to Health Insurance for People with Medicare" which was given to you; please see page 7 of the Buyers Guide.

DESCRIPTION	THIS POLICY PAYS	YOU PAY

I. Minimum Standards

SERVICE

PART A

INPATIENT HOSPITAL SERVICES:

Semi-Private Room and Board

Miscellaneous Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room

BLOOD

PART B

MEDICAL EXPENSE:

Services of a Physician/ Outpatient Services

Medical Supplies other than Prescribed Drugs

BLOOD

MISCELLANEOUS

Immunosuppressive Drugs

****

II. Additional Benefits

DESCRIPTION	THIS POLICY PAYS	YOU PAY
PART A		
PART A DEDUCTIBLE		
Private Rooms		
In-Hospital Private Nurses		
Skilled Nursing Facility Care		
PART A & B		
Home Health Services		
PART B		
PART B DEDUCTIBLE		
Medical Charges in Excess of Medicare Allowable Expenses (Percentage Paid)		
OUT-OF-POCKET MAXIMUM		
PRESCRIPTION DRUGS		
MISCELLANEOUS		
Respite Care Benefits		
Expenses Incurred in Foreign Country		
Other:		
TOTAL PREMIUM		$_____

IN ADDITION TO THIS OUTLINE OF COVERAGE [INSURANCE COMPANY NAME] WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

**If this policy does not provide coverage for a benefit listed above, the insurer must state "no coverage" beside that benefit in the first column.

5. A copy of the notice as provided for in §13(B) and found at Appendix A must accompany the outline of coverage.

6. Statement that the policy does or does not cover the following:

   (a) Private duty nursing;

   (b) Skilled nursing home care costs (beyond what is covered by Medicare);

   (c) Custodial nursing home care costs;

   (d) Intermediate nursing home care costs;

   (e) Home health care above number of visits covered by Medicare;

   (f) Physician charges (above Medicare's reasonable charge);

   (g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay);

   (h) Care received outside the U.S.A.;

   (i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.

7. A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in (4) above, including conspicuous statements:

   (a) That the chart summarizing Medicare benefits only briefly describes such benefits.

   (b) That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.

8. A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.

9. The amount of premium for this policy.

10. Must include the agent's name, both printed and in signature form, and the signature of the applicant.

APPENDIX C

ARKANSAS INSURANCE DEPARTMENT
MEDICARE SUPPLEMENT REPLACEMENT COMPARISON SHEET

	Present Coverage	Proposed Coverage
1. Company name		
2. Policy or application number		
3. Policy form number		
4. Name of writing agent		
5. Does applicant have Medicare Part A Hospital Insurance? (yes/no)		
Does applicant have Medicare Part B Medical Expense Insurance? (yes/no)		
6. Premium (Compare only identical modes of payment i.e. months to months)		

MEDICARE (PART A) HOSPITAL INSURANCE

If any of these coverages are provided only at an additional cost, write the cost on the line with the response.

	Present Coverage	Proposed Coverage
7. Does policy cover: Medicare Part A Initial Hospitalization Deductible? (yes/no)		
8. Does policy cover: First 3 pints of blood? (yes/no)		
9. Does policy cover: Private Hospital Room? (yes/no)		
10. Does policy cover: Private Duty Nurse? (yes/no)		
11. Does policy cover: World Wide Coverage? (yes/no)		
12. Does policy pay copayment for 1st 20 days of skilled nursing facility care? (yes/no)		

13. Is coverage provided for nursing facility/swing bed care? (Indicate amount and # of days)
    Skilled _____ _____
    Intermediate _____ _____
    Custodial _____ _____

14. Are nursing facility/swing bed benefits paid even if Medicare does not? (yes/no) _____ _____

15. Are home health care benefits payable in addition to Medicare's benefit? (yes/no) _____ _____

16. Are hospice benefits payable in addition to Medicare's benefit? (yes/no) _____ _____

MEDICARE (PART B): MEDICAL INSURANCE COVERED SERVICES PER CALENDAR YEAR

If any of these coverages are provided only at an additional cost, write the cost on the line with the response.

	Present Coverage	Proposed Coverage
17. Does policy cover: Medicare Part B Deductible? i.e. physicians services, inpatient and outpatient medical services and supplies, physical & speech therapy, ambulance, etc. (yes/no) (if yes, how much)	_____	_____
18. What is the percentage of coverage on Medicare approved charges? (indicate amount)	_____	_____

19. What is the amount paid on remaining Part B:

    a. Co-payment of Medicare allowable charges only (20%) _____ _____

    b. Payment on "excess charges":

        (1) Up to actual charges _____ _____
        (2) Up to UCR charges _____ _____
        (3) Possibly up to UCR charges but with a % limit (based on the Medicare allowable charge) state percentage _____ _____

20. Is coverage provided without physician restrictions? (yes/no) _____ _____

21. Indicate company restrictions on maximum amounts payable above Medicare's approved charges. _____ _____

22. Are home health care benefits paid in addition to Medicare's benefit? (yes/no) _____ _____

23. Will benefits cover Medicare's blood deductible and co-payment for Part B? (yes/no) _____ _____

24. Are outpatient prescription drugs covered? (yes/no) _____ _____

25. Will benefits payable under policy change as Medicare changes? (yes/no) _____ _____

26. Comparison Summary

    If accepted, what waiting period applies to pre-existing conditions?

    a) Under the Policy b) for this insured

    _____

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application], you intend to lapse or otherwise terminate existing Medicare Supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all disability coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets, as necessary),

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

[This subsection may be modified if preexisting conditions are covered under the new policy.]

2. State law provides that your replacement policy or certificate, may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing Medicare Supplement insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present poliy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

_____ _____

Signature of Agent, Broker or Other Representative Date

_____

[Typed name and Address of Agent or Broker]

The above "Comparison of Benefits/Notice to Applicant" was delivered to me on:

_____

Date

_____ _____

Applicant's Signature Spouse Signature:
(if listed on same application)

APPENDIX D

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing Medicare Supplement insurance and replace it with the policy delivered herewith issued by [Company Name] Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware if and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all disability coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate, may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing Medicare Supplement insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [Company Name and Address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____ _____

Company Name Company Representative Signature

APPENDIX E

FORM FOR REPORTING MULTIPLE
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this State who has in force more than 1 Medicare Supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (Please Type)

_____
Date