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DEPARTMENT OF COMMERCE AND INSURANCE
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PAULA A. FLOWERS
COMMISSIONER

BULLETIN

TO: All Accident and Health Insurers Doing Business in this State

FROM: Paula A. Flowers, Commissioner Paula A. Flowers
Department of Commerce and Insurance

RE: Eligibility of Former TennCare Enrollees to Obtain Health Insurance Coverage under the Tennessee Health Insurance Portability, Availability and Renewability Act

DATE: July 5, 2005

The purpose of this Bulletin is to communicate the Department's position regarding the eligibility of former TennCare enrollees to obtain health insurance coverage under the Tennessee Health Insurance Portability, Availability and Renewability Act (hereinafter "HIPAA"), Tenn. Code Ann. §§ 56-7-2801, *et seq.* Be advised that it is the Department's position that TennCare coverage qualifies as "creditable coverage" under HIPAA and insurers should not, therefore, discriminate against former enrollees in providing them access to both group coverage as well as individual HIPAA guaranteed issue plans.

1. TennCare is Creditable Coverage

The Department's position concerning this issue has recently been addressed and confirmed in an opinion issued by the Office of the Attorney General and Reporter, Opinion Number 05-097, on June 20, 2005. A copy of the aforementioned opinion is attached hereto.

A. Group Health Insurance Coverage

Therefore, if all of the eligibility requirements contained in Tenn. Code Ann. § 56-7-2803 are met, a former enrollee is qualified to obtain group health insurance coverage. Under this statute, a former enrollee may apply for coverage under a group health plan for which he or she otherwise qualifies as an employee within thirty (30) days of losing TennCare coverage. The group health plan may not exclude coverage for preexisting medical conditions if a former enrollee was covered by TennCare within the periods specified in Tenn. Code Ann. § 56-7-2803.

B. Individual Health Insurance Coverage

Additionally, if all of the eligibility requirements contained in Tenn. Code Ann. § 56-7-2809 are met, a former enrollee is qualified to obtain individual health insurance coverage. Under this statute, a former enrollee may apply for coverage under an individual health plan if he or she has had TennCare coverage (or other creditable coverage) for at least eighteen (18) months with no gaps in coverage exceeding sixty-three (63) days. The individual health plan may not impose any preexisting condition exclusion with respect to such enrollment. An insurer failing to treat TennCare as creditable coverage may become subject to sanctions pursuant to Tenn. Code Ann. § 56-1-416.

2. Insurer's Obligation to Determine HIPAA Eligibility

In addition, it has come to the Department's attention that some insurers and their insurance producers may be avoiding their obligations under HIPAA by not informing a health insurance applicant of his or her rights to such coverage. Pursuant to 45 CFR § 148.126, insurers offering coverage in the individual market have an obligation to use "reasonable diligence" in determining whether an applicant is an eligible individual. Specifically, 45 CFR § 148.126 states the following:

§ 148.126 Determination of an eligible individual.

(a) General rule. Each issuer offering health insurance coverage in the individual market is responsible for determining whether an applicant for coverage is an eligible individual as defined in § 148.103.

(b) Specific requirements.

(1) The issuer must exercise reasonable diligence in making this determination.

(2) The issuer must promptly determine whether an applicant is an eligible individual.

(3) If an issuer determines that an individual is an eligible individual, the issuer must promptly issue a policy to that individual.

(c) Insufficient information - (1) General rule. If the information presented in or with an application is substantially insufficient for the issuer to make the determination described in paragraph (b)(2) of this section, the issuer may immediately request additional information from the individual, and must act promptly to make its determination after receipt of the requested information.

Be advised that it is the Department's position that an insurer does not exercise "reasonable diligence" unless it makes reasonable and continuing efforts to determine whether an applicant for any type of coverage in the individual market (including medically underwritten and conversion products) is an eligible individual. This requirement applies regardless of an applicant's knowledge of his or her rights under the statute or if an applicant specifically applied for a HIPAA product. Additionally, reliance by an insurer on its producers does not constitute

"reasonable diligence" unless an insurer makes reasonable and continuing efforts to ensure that its producers are in compliance with the regulations. While many insurers may have conducted initial producer training concerning HIPAA compliance in 1997 or 1998, all insurers should continue to provide in-service training on how to screen for HIPAA eligibility and what the law requires once an eligible individual is identified. An insurer failing to exercise "reasonable diligence" pursuant to 45 CFR § 148.126 may become subject to sanctions pursuant to Tenn. Code Ann. § 56-1-416.

As a result of the current disenrollment process being conducted by TennCare, many former enrollees will only have access to private health insurance through HIPAA. As such, the Department will closely monitor and investigate any complaints it receives concerning insurers not complying with the portability and availability requirements of HIPAA. Insurers should expect any violations of HIPAA to be treated quickly and severely.

Should you have any questions concerning the position set forth in this Bulletin, or its application, please contact Larry C. Knight, Jr., Assistant Commissioner for the Insurance Division, Fourth Floor, Davy Crockett Tower, 500 James Robertson Parkway, Nashville, Tennessee, 37243, and/or telephone number (615) 741-2176.

JAS/

STATE OF TENNESSEE
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ATTORNEY GENERAL
PO BOX 20207
NASHVILLE, TENNESSEE 37202

June 20, 2005

Opinion No. 05-097

Alternative Coverage for Individuals Disenrolled from TennCare

QUESTIONS

1. Does coverage under TennCare qualify as "creditable coverage" under Tenn. Code Ann. §§ 56-7-2801, *et seq.*?

2. Is a disenrolled TennCare enrollee qualified to obtain group health insurance in Tennessee?

3. Is a disenrolled TennCare enrollee qualified to obtain individual health insurance in Tennessee?

OPINIONS

1. Yes.

2. A disenrolled TennCare enrollee is entitled to enroll for coverage under group health insurance as provided in Tenn. Code Ann. § 56-7-2803. Under that provision, the disenrollee may apply for coverage under a group plan for which he or she otherwise qualifies as an employee within thirty days of losing TennCare coverage. The plan may not exclude coverage for preexisting medical conditions if the individual was covered by TennCare within the periods specified in Tenn. Code Ann. §§ 56-7-2801, *et seq.*

3. The key issue in this question is whether TennCare coverage qualifies as creditable coverage under a "group health plan" within the meaning of Tenn. Code Ann. § 56-7-2809(b)(1). Neither the statutory language nor the legislative history of the statute as amended is entirely clear. But we think the courts would interpret the statute to include creditable coverage under TennCare as creditable coverage under a "group health plan" within the meaning of Tenn. Code Ann. § 56-7-2809(b)(1). Under this interpretation, a disenrolled TennCare enrollee would be entitled to obtain individual health care insurance as set forth in Tenn. Code Ann. § 56-7-2809.

ANALYSIS

This opinion concerns treatment of disenrolled TennCare enrollees under Tenn. Code Ann. §§ 56-7-2801, *et seq.* This statutory scheme represents Tennessee's implementation of requirements

under the Health Insurance Portability and Accountability Act, U.S. P.L. 104-191, commonly referred to as "HIPAA." This act gives states the option of implementing and enforcing the portability requirements under the federal law, or allowing federal authorities to do so. 42 U.S.C. § 300gg-22 (group health insurance); 42 U.S.C. § 300gg-61 (individual health insurance). The state law was enacted as 1997 Tenn. Pub. Acts Ch. 157. The legislative history of the 1997 act provides no guidance on the issues raised in this request.

Section 15 of the 1997 state act, codified at Tenn. Code Ann. § 56-7-2814, provides:

> It is the intent of this part to meet the minimum standards established by the federal Health Insurance Portability and Accountability Act of 1996 and the rules and regulations to be promulgated by federal authorities in connection with that act. The commissioner is, therefore, authorized to promulgate rules and regulations, pursuant to the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5, as may be necessary to ensure compliance with the federal law as well as those rules necessary to carry out the proper administration of this part.

1997 Tenn. Pub. Acts Ch. 157, Section 15. In fact, as discussed below, the federal law does not explicitly include persons who have been disenrolled from Medicaid within some of the categories protected under the new act. It is not clear, therefore, whether the state law in fact goes beyond the minimum standards set by the federal law. But the state law was amended in 2001 to include individuals who have lost TennCare coverage where the federal law does not. 2001 Tenn. Pub. Acts Ch. 262. The legislative history of the 2001 act reflects that it was intended to give TennCare recipients the same privileges as individuals who lose coverage under an employee health plan. The legislative history for both the 1997 and the 2001 acts reflects that the sponsors thought the bill was necessary to bring the State into compliance with HIPAA regulations. The state law has also included a broader definition of "group health plan" than does the federal law since the state law was passed in 1997. Despite section 15 of the 1997 act, therefore, the statutory language and the legislative history of the 2001 amendment support including TennCare coverage for certain purposes even if the federal law does not.

1. Creditable Coverage

The first question is whether TennCare coverage is "creditable coverage" under Tenn. Code Ann. §§ 56-7-2801, *et seq.* Tenn. Code Ann. § 56-7-2802(6)(A) states:

> [As used in this part, unless the context otherwise requires:]
>
> "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:
>
> * * * *

> (iv) The Social Security Act, Title XIX, other than coverage consisting solely of benefits under § 1928;
>
> * * * *
>
> (ix) A public health plan;

A similar definition of "creditable coverage" appears in the federal HIPAA law. 42 U.S.C. § 300gg(c)(1). The Social Security Act, Title XIX, refers to the Medicaid law, 42 U.S.C. § 1396. The TennCare Program is authorized under those provisions. The statute excludes "coverage consisting *solely* of benefits under § 1928" of the Social Security Act. (Emphasis added). This provision refers to the pediatric vaccination program authorized under 42 U.S.C. § 1396s. Since TennCare is not "coverage consisting solely of benefits" under this pediatric vaccination program, it is clearly a form of "creditable coverage" under the Tennessee insurance portability law as well as the federal HIPAA law. In fact, the TennCare Bureau already issues a Certificate of Group Health Plan Coverage that refers to TennCare coverage as "creditable coverage."

2. Ability of Disenrolled TennCare Enrollee to Obtain Group Health Insurance

The second question is whether a disenrolled TennCare enrollee is qualified to obtain group health insurance in Tennessee. The statute defines "group health insurance coverage" to mean, in connection with a group health plan, health insurance coverage offered in connection with such plan. Tenn. Code Ann. § 56-7-2802(13). The term "group health plan":

> means an employee welfare benefit plan (as defined in ERISA, § 3(1)) to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. *A program under which creditable coverage is provided shall be treated as a group health plan for the purposes of applying this part.*

Tenn. Code Ann. § 56-7-2802(14). (Emphasis added). The italicized sentence does not appear in the definition of "group health plan" in the federal law. 42 U.S.C. § 300gg-91(a)(1). The term "employee welfare benefit plan" is defined in 29 U.S.C. § 1002 broadly to include "any plan, fund, or program which was . . . established or maintained by an employer or an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits." 29 U.S.C. § 1002(1).

Tenn. Code Ann. § 56-7-2803 limits the ability of a group health plan or a "health insurance issuer offering group health insurance coverage" to impose a preexisting condition exclusion with respect to a participant or beneficiary. The term "health insurance issuer" means:

> an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract

> to provide health insurance coverage, including but not limited to an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation. "Health insurance issuer" does not include a group health plan.

Tenn. Code Ann. § 56-7-2802 (16). The term "health insurance coverage" means:

> Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any policy, certificate, or agreement offered by a health insurance issuer.

Tenn. Code Ann. § 56-7-2802(15). Presumably the term "health insurance issuer offering group health insurance coverage" refers to health insurance issued on a group basis by a health insurance issuer, which term expressly excludes employee welfare benefit plans.

The limit on imposing preexisting condition exclusions protects both a "participant" and a "beneficiary." The term "participant" has the meaning given such term under ERISA, § 3(7), now codified at 29 U.S.C § 1002(7). Tenn. Code Ann. § 56-7-2802(26). Under that statute:

> The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

The term "beneficiary" has the meaning given such term under ERISA § 3(8), now codified at 29 U.S.C. § 1002(8). Tenn. Code Ann. § 56-7-2802(2). Under that ERISA statute:

> The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

Tenn. Code Ann. § 56-7-2803(a) restricts the conditions under which a group health plan and health insurance issuer offering group health insurance coverage may impose a preexisting condition exclusion on participants and beneficiaries. The exclusion may not extend for a period of more than twelve months, or eighteen in the case of a late enrollee after the enrollment date, and this period must be reduced by the aggregate of periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date. Group health plans and health insurance issuers offering group health insurance coverage must provide certification of creditable coverage to individuals who cease to become covered under the plan. Because of the italicized sentence in the definition of "group health plan," this requirement extends to TennCare. Again, we are informed that TennCare has been routinely issuing certificates of creditable coverage to TennCare disenrollees.

Subsection (h) of Tenn. Code Ann. § 56-7-2803 sets special enrollment periods for individuals who opted out of a group health insurance plan because other coverage was available, and then lost the alternate coverage. The statute, as amended in 2001, explicitly includes TennCare within the definition of "health insurance coverage." The statute provides in relevant part:

> (1) FOR INDIVIDUALS LOSING OTHER COVERAGE. A*s used in this subsection, the phrase "health insurance coverage" shall include the TennCare program as administered by the department of finance and administration.*
>
> (2) A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan . . . to enroll for coverage under the terms of the plan if each of the following conditions is met:
>
> (A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.
>
> (B) The employee stated in writing at such time that coverage under a group plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.
>
> (C) The employee's or dependent's coverage described in subdivision (h)(2)(A):
>
> (i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or
>
> (ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage . . . or employer contributions toward such coverage were terminated.
>
> (D) Under the terms of the plan, the employee requests such enrollment not later than thirty (30) days after one (1) of the events described in subdivision (h)(2)(C).

(Emphasis added). The statute includes provisions for dependents of individuals qualified for group health plan coverage also to receive coverage. Again, the parallel provision in federal law does not

include the express reference to TennCare, or any reference to Medicaid at all. 42 U.S.C. § 300gg(f). Subdivision (h)(1) was added by a 2001 amendment. 2001 Tenn. Pub. Acts Ch. 262. Representative Hargett, who sponsored the bill in the House, explained it to the House Commerce Committee as follows:

> What the bill does as amended is, loss of TennCare eligibility currently does not qualify as a special enrollment period under state HIPAA statutes. Therefore, a person who loses a TennCare eligibility would not be able to immediately enroll in their employee — possible employee insurance program, and this will rectify that problem.

House Commerce Committee, April 24, 2001 (remarks of Rep. Hargett).

Senator Clabough explained the bill to the Senate Finance Ways and Means Committee as follows:

> This bill came through our commerce committee, and the bill gives TennCare recipients the same privileges as other people under the group insurance plans, and it brings us in compliance with the HIPAA. If a person has insurance for twelve months and then has been without coverage for no more than six months, they cannot be required to wait for a special enrollment period or be denied because of a preexisting condition.

Senate Finance Ways and Means Committee, May 8, 2001 (remarks of Sen. Clabough).

Legislative history of the bill, therefore, reflects the legislators' intent to treat loss of TennCare the same as loss of coverage under an employer's group health plan. Under state law, therefore, a disenrolled TennCare enrollee is entitled to enroll for coverage under group health insurance as provided in Tenn. Code Ann. § 56-7-2803. Under that provision, the disenrollee may apply for coverage under a group plan for which he or she otherwise qualifies as an employee within thirty days of losing TennCare coverage. The plan may not exclude coverage for preexisting medical conditions if the individual was covered by TennCare within the periods specified in Tenn. Code Ann. §§ 56-7-2801, *et seq.*[1]

3. Availability of Individual Health Care Insurance

The last question is whether a disenrolled TennCare enrollee is qualified to obtain individual health insurance in Tennessee under Tenn. Code Ann. §§ 56-7-2801, *et seq.* The applicable state statute is Tenn. Code Ann. § 56-7-2809. Under section (a) of that statute, "each health insurance issuer that offers individual health insurance coverage in Tennessee *must* offer to accept for

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[1] To the extent state law in this respect goes beyond federal HIPAA protections, it may be preempted with respect to some employee benefit plans subject to regulation under federal ERISA law.

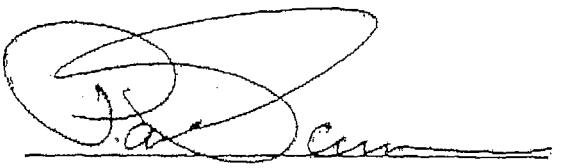
enrollment every eligible individual who applies for coverage *without imposing any preexisting condition exclusion with respect to such coverage*." (Emphasis added). Under this provision, anyone who qualifies as an "eligible individual" is entitled to purchase individual health insurance from an insurance company that offers such insurance in Tennessee. The insurance company may not exclude coverage for any preexisting medical conditions. It should be noted that the statute does not attempt to limit the price the insurer can charge for the insurance. The issue then becomes whether a TennCare disenrollee is an "eligible individual" within the meaning of the statute. The statute defines this term as follows:

> (b) "eligible individual" means an individual:
>
> (1) For whom, as of the date on which the individual seeks coverage under this section, the aggregate of periods of creditable coverage is eighteen (18) or more months and *whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan* (or health insurance coverage offered in connection with any such plan);
>
> (2) Who is not eligible for coverage under a group health plan, the Social Security Act, Part A or Part B of Title XVII, or state coverage pursuant to the Social Security Act, Title XIX (or any successor program), and does not have other health insurance coverage;
>
> (3) Whose most recent coverage within the coverage period described in subdivision (b)(1) was not terminated based on nonpayment of premiums or fraud; and
>
> (4) Who, if offered the option of continuation coverage, accepted the coverage and exhausted the coverage.

Tenn. Code Ann. § 56-7-2809(b) (emphasis added).

The key issue is whether creditable coverage under TennCare qualifies as a "group health plan, governmental plan, or church plan" within the meaning of Tenn. Code Ann. § 56-7-2809(b)(1). As discussed above, the term "governmental plan" as used in the statute refers to a plan offered to governmental employees. Nor would TennCare qualify as a "church plan." The question then becomes whether TennCare qualifies as a "group health plan" within the meaning of this statute. Neither the legislative history of the state law nor the state statutory language is entirely clear. But we think the courts would interpret the statute to include creditable coverage under TennCare as creditable coverage under a "group health plan" within the meaning of Tenn. Code Ann. § 56-7-2809(b)(1). The definition of "group health plan" in Tenn. Code Ann. § 56-7-2802(14) supports this interpretation. The last sentence of that definition provides: "A program under which creditable coverage is provided *shall* be treated as a group health plan for the purposes of applying this part."

Neither the legislative history of the state law nor the state statutory language is entirely clear. But we think the courts would interpret the statute to include creditable coverage under TennCare as creditable coverage under a "group health plan" within the meaning of Tenn. Code Ann. § 56-7-2809(b)(1). The definition of "group health plan" in Tenn. Code Ann. § 56-7-2802(14) supports this interpretation. The last sentence of that definition provides: "A program under which creditable coverage is provided *shall* be treated as a group health plan for the purposes of applying this part." (Emphasis added). Further, as discussed above, the General Assembly amended the statute in 2001 to provide that an individual disenrolled from TennCare may apply for coverage under an employment plan that he or she had earlier elected not to enroll in because of the availability of TennCare. The statute, therefore, now treats coverage under TennCare for this purpose the same as coverage under an employee group insurance plan. This change, along with the definition of group health plan, strengthens the argument that TennCare coverage should be treated as "creditable coverage under a group health plan" within the definition of "eligible individual." Under this interpretation, a disenrolled TennCare enrollee would be entitled to purchase individual insurance as provided in Tenn. Code Ann. § 56-7-2809.



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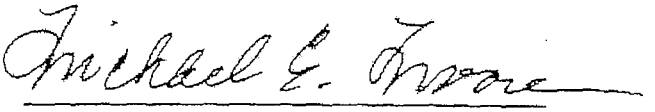

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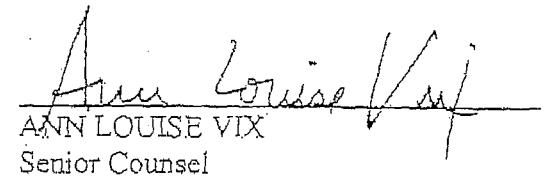

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HIPAA PLANS AND INDIVIDUAL HEALTH INSURERS

If you are losing TennCare coverage, or leaving an employer sponsored group insurance plan (after exhausting your COBRA benefits, state continuation or neither if continuation is not available), you have certain rights under state and federal HIPAA laws (Health Insurance Portability and Accountability Act). If you have had eighteen (18) months of prior health insurance coverage with no gaps exceeding sixty-three (63) days, then you cannot be denied coverage due to a pre-existing medical condition. However, you must seek new health insurance coverage immediately upon termination of your prior coverage in order to be protected. The following deadlines are critical:

1. **Group plans** – Even if you were on TennCare a short amount of time, you may be eligible to join a group plan offered by your or your spouse's employer. You have thirty **(30) days** after termination of your prior coverage to join a group plan. After this 30 day period, you may be deemed uninsurable.

2. **Individual plans** – You are eligible to purchase an individual plan if you had 18 months continuous coverage under TennCare or another group plan. You have sixty-three **(63) days** after termination of your prior coverage to purchase an individual insurance plan. After this 63 day period, you may be deemed uninsurable.

3. **Pre-existing condition waiting periods** – If you have had eighteen (18) months or more of continuous health insurance coverage, then you cannot be subjected to a pre-existing condition waiting period. If applying for a group plan, any period of coverage less than 18 months may act as a "credit" against any pre-existing condition waiting periods imposed by your new health insurance carrier.

The following list of companies all offer individual plans, including HIPAA plans, in Tennessee. When calling for price quotes, you need to specify that you are seeking a "HIPAA" or "guaranteed issue" plan. This list may not be complete and changes in those companies offering individual health products occur frequently. **We are not recommending any company on this list.** For further information, please contact the Consumer Insurance Section at the number listed above.

American Medical Security Life Ins. Co
3100 AMS Blvd, P.O. Box 19032
Green Bay, WI 54307-9032
(800) 232-5432
www.eams.com

American National Life Ins. Co. of Texas
One Moody Plaza
Galveston, TX 77550-7999
(800) 899-6503
www.anico.com

American Republic Ins. Co.
P. O. Box 1
Des Moines, IA 50334
(800) 247-2190
www.aric.com

Blue Cross and Blue Shield of Tennessee
801 Pine Street
Chattanooga, TN 37402
(800) 565-9140
www.bcbst.com

Celtic Insurance Company
233 South Wacker Dr., Suite 700
Chicago, IL 60606-6393
(800) 477-7990
www.celtic-net.com

Central Reserve Life Insurance Co.
17800 Royalton Rd.
Strongsville, OH 44136
(800) 321-3997
www.centralreserve.com

Continental General Ins. Co.
8901 Indian Hills Drive
Omaha, NE 68114
(800) 545-8905
www.continentalgeneral.com

Empire Fire & Marine Ins. Company
13810 First National Bank Parkway
Omaha, NE 68154-5202
(800) 878-0011
www.usselectmarketing.om

Fortis Benefits Insurance Company
500 Bielenberg Drive
Woodbury, Minnesota 55125
(866) 884-4636
www.assuranthealth.com

Fortis Ins. Co.
P. O. Box 3050
Milwaukee, WI 53201-3050
(866) 884-4636
www.assuranthealth.com

Freedom Life Ins. Company of America
110 West Seventh St., Suite 300
Ft. Worth, TX 76102
(800) 387-9027
www.freedomlife.net

Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, IL 62439-2395
(800) 444-8990
www.goldenrule.com

Humana Ins. Co.
P.O. Box 30111
Tampa, FL 33630-3111
(866) 672-9165
www.humana.com

MEGA Life and Health Ins. Company
P.O. Box 982010
North Richland Hills, TX 76182-8010
(800) 527-5504
www.megainsurance.com

Mid-West National Life Ins. Co. of TN
4001 McEwen Rd., Suite 200
Dallas, TX 75244
(800) 729-2302
www.healthinsuranceandmore.com

National Foundation Life Ins. Co.
110 West Seventh St., Suite 300
Ft. Worth, TX 76102
(800) 221-9039
www.freedomlife.net

Physicians Mutual Ins. Co.
2600 Dodge Street
Omaha, NE 68131
(800) 932-7642
www.physiciansmutual.com

United American Insurance Co.
P. O. Box 810
Dallas, TX 75221-0810
(972) 529-5085
www.unitedamerican.com

World Insurance Company
P. O. Box 3160
Omaha, NE 68103-0160
(800) 786-7557
www.worldinsco.com