AMENDED FILING EXPLANATION

Filing amended to include Medicare Supplement Interrogatories electronic data for all states and territories.

PROPERTY AND CASUALTY COMPANIES - ASSOCIATION EDITION

11991201620100105

ANNUAL STATEMENT

For the Year Ended December 31, 2016

of the Condition and Affairs of the

NATIONAL CASUALTY COMPANY

NAIC Group Code..... 0140, 0140 (Current Period) (Prior Period) NAIC Company Code..... 11991 Employer's ID Number..... 38-0865250

Organized under the Laws of OH State of Domicile or Port of Entry OH Country of Domicile US

Incorporated/Organized..... December 19, 1904 Commenced Business..... December 31, 1904

Statutory Home Office ONE WEST NATIONWIDE BLVD, 1-04-701….. Columbus ..... OH ..... US 43215-2220
(Street and Number) (City or Town, State, Country and Zip Code)

Main Administrative Office 8877 N. GAINEY CENTER DRIVE….. SCOTTSDALE ..... AZ ..... US..... 85258-2108 480-365-4000
(Street and Number) (City or Town, State, Country and Zip Code) (Area Code) (Telephone Number)

Mail Address ONE WEST NATIONWIDE BLVD, 1-04-701….. COLUMBUS .... OH .... US 43215-2220
(Street and Number or P. O. Box) (City or Town, State, Country and Zip Code)

Primary Location of Books and Records ONE WEST NATIONWIDE BLVD, 1-04-701.. COLUMBUS OH US 43215-2220 614-249-1545
(Street and Number) (City or Town, State, Country and Zip Code) (Area Code) (Telephone Number)

Internet Web Site Address WWW.SCOTTSDALEINS.COM

Statutory Statement Contact CHERYL M. DENNIS 614-249-1545
(Name) (Area Code) (Telephone Number) (Extension)

FINRPT@NATIONWIDE.COM 866-315-1430
(E-Mail Address) (Fax Number)

OFFICERS

Name	Title	Name	Title
1. THOMAS EDWARD CLARK	PRESIDENT	2. ROBERT WILLIAM HORNER III	VP & SECRETARY
3. KENNETH ARI LEVINE	VP & TREASURER		

OTHER

PAMELA ANN BIESECKER	SR VP-HEAD OF TAXATION	MICHAEL ALOYSIUS BOYD	SR VP-ENTERPRISE BRAND MRKT
MARTHA LOVETTE FRYE	SR REG VP-SOUTHEAST EXCL DIST	THOMAS WAYNE JURGENS	SR VP- BRKG-EXCESS & SURPLUS
DAVID NEIL NELSON	SR VP-CONTRACT & PRGM UNDRW		

DIRECTORS OR TRUSTEES

MARK ALLEN BERVEN	THOMAS EDWARD CLARK	THOMAS WAYNE JURGENS	MICHAEL PATRICK LEACH
DAVID NEIL NELSON			

State of..... OHIO
County of..... FRANKLIN

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC *Annual Statement Instructions* and *Accounting Practices and Procedures* manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

(Signature)	(Signature)	(Signature)
THOMAS EDWARD CLARK	ROBERT WILLIAM HORNER III	KENNETH ARI LEVINE
1. (Printed Name)	2. (Printed Name)	3. (Printed Name)
PRESIDENT	VP & SECRETARY	VP & TREASURER
(Title)	(Title)	(Title)

Subscribed and sworn to before me
This _____ day of _____ 2017

a. Is this an original filing? Yes [ ] No [X]

b. If no
1. State the amendment number 1
2. Date filed 5/15/2017
3. Number of pages attached 56

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Alaska

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.AK

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Alabama

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991
Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.AL

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Arkansas

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991
Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.AR

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....American Samoa

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991
Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.AS

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Arizona

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.AZ

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....California

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.CA

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Colorado

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.CO

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Connecticut

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.CT

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....District of Columbia

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.DC

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Delaware

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.DE

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Florida

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.FL

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Georgia

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.GA

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Guam

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.GU

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Hawaii

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.HI

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Iowa

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.IA

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Idaho

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.ID

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Illinois

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.IL

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Indiana

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360 IN

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Kansas

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.KS

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Kentucky

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.KY

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Louisiana

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991
Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.LA

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Massachusetts

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.MA

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Maryland

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.MD

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Maine

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.ME

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Michigan

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.MI

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Minnesota

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

NONE

360.MN

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Missouri

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.MO

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Northern Mariana Islands

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991
Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.MP

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Mississippi

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.MS

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Montana

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991
Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.MT

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....North Carolina

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.NC

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....North Dakota

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.ND

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Nebraska

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.NE

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....New Hampshire

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.NH

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....New Jersey

NAIC Group Code.....0140
Address (City, State and Zip Code).....Scottsdale, AZ 85258-2108
Person Completing This Exhibit.....Joshua C. Kopechek

NAIC Company Code.....11991

Title.....Consultant Accounting.....Telephone Number.....614-677-6125

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
Individual Policies																	
	8427	P	NO	34000				.01/01/1992		542	3,524	650.2	4			0.0	
0199999.	Total Policy Experience on Individual Policies									542	3,524	650.2	4	0	0	0.0	0

360.NJ

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number..... Joshua C. Kopechek 614-677-6125
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number..... Joshua C. Kopechek 614-677-6125
4. Explain any policies identified as policy type "O".

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....New Mexico

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.NM

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Nevada

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.NV

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....New York

NAIC Group Code.....0140
Address (City, State and Zip Code).....Scottsdale, AZ 85258-2108
Person Completing This Exhibit.....Joshua C. Kopechek

NAIC Company Code.....11991

Title.....Consultant Accounting.....Telephone Number.....614-677-6125

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
Individual Policies																	
	8427	P	NO	34000				.01/01/1992		1,001	(622)	(62.1)	3			0.0	
	9033	P	NO	34000				.01/01/1992		3,573	4,890	136.9	10			0.0	
0199999.	Total Policy Experience on Individual Policies									4,574	4,268	93.3	13	0	0	0.0	0

360.NY

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number..... Joshua C. Kopechek 614-677-6125
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number..... Joshua C. Kopechek 614-677-6125
4. Explain any policies identified as policy type "O".

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Ohio

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.OH

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Oklahoma

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.OK

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Oregon

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.OR

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Pennsylvania

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.PA

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Puerto Rico

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.PR

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Rhode Island

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.RI

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....South Carolina

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.SC

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....South Dakota

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.SD

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Tennessee

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.TN

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Texas

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.TX

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Utah

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.UT

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Virginia

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.VA

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....U.S. Virgin Islands

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991
Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.VI

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Vermont

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

NONE

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

360.VT

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Washington

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.WA

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Wisconsin

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991
Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.WI

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....West Virginia

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991

Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.WV

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE

Supplement for the year 2016 of the **NATIONAL CASUALTY COMPANY**

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For the Year Ended December 31, 2016
(To Be Filed by March 1)
FOR THE STATE OF.....Wyoming

NAIC Group Code.....0140
Address (City, State and Zip Code).....
Person Completing This Exhibit.....

NAIC Company Code.....11991
Title.....Telephone Number.....

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014, 2015 & 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives
									NONE								

360.WY

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details.....

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
   2.1 Address.....
   2.2 Contact person and phone number.....
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
   3.1 Address.....
   3.2 Contact person and phone number.....
4. Explain any policies identified as policy type "O".

NONE