

(LTR NAME: MEDICARE SUPPLEMENT RATE INCREASE - NEW YORK-  
PRESTANDARD)  
(ADDED: 09-13-11)  
(CARBON COPIES: 2)  
(DUPLEX: Y)  
(DISPLAY LETTER: Y)  
<CURRENT DATE>

<INSURED NAME & ADDRESS>  
<INSURED NAME & ADDRESS>

Re: H<POLICY NUMBER> <PST>

Dear <INSURED LAST NAME>:  
<BEGIN BODY>

This is to provide notice as required pursuant to New York Insurance Article 32 Section 3231 (e)(1)(a) that State Farm Mutual Automobile Insurance Company filed on September 16, 2011 with the New York State Insurance Department for an average increase in the amount of 2.8% for Pre-Standardized Medicare Supplement policies.

The impact on your rates may vary depending on the terms of your policy and your individual circumstances.

The request for a rate increase is subject to review and approval by the New York State Insurance Department pursuant to the law, and the request may not be approved or may not be approved for the full amount requested. If approved in whole or in part, the rate change will not affect existing policies until their next anniversary.

Estimated rates including the full requested increase have been included in the enclosed materials.

You may submit written comments or request additional information on the proposed rates within 30 days of the rates being submitted. Comments may be sent to the New York Department of Insurance at the following address:

#BEGIN TABLE

James Carroll  
Health Bureau  
New York State Insurance Department  
One Commerce Plaza  
Albany, NY 12257

Or if you prefer to  
email, ¢PremiumRateIncreases@ins.state.ny.us¢

#END TABLE

To write us here at State Farm Mutual Automobile Insurance  
Company, please use this address:

#BEGIN TABLE

State Farm Mutual Automobile Insurance Company  
1 State Farm Plaza  
Bloomington, IL 61701  
866-855-1212

Or if you prefer, please contact us online at:

¢[https://online.statefarm.com/apps/contactSF/pages/commentsSugge  
stions.asp](https://online.statefarm.com/apps/contactSF/pages/commentsSugge<br/>stions.asp)

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#END TABLE

<END OF BODY>

Sincerely,

Policyholder Service  
Health Insurance Division  
<#CO NAME 1><#CO NAME 2><#CO NAME 3>

CC: <EM AGT NAME>, <PST>--<EM AGT CODE>

#BEGIN TABLE

\Pre- Standardized Medicare Supplement Plans\  
\Rate Comparison\  
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	Current	Proposed
Form 97033	\$3,019.68	\$3,104.33
Form 97049	\$2,286.47	\$2,350.56

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