

MEDICARE SUPPLEMENT

Insurance Application



FINANCIAL RESOURCES

Supplemental Benefits Group

Our Companies include:

Central Reserve Life Insurance Company
Continental General Insurance Company
Great American Life Insurance Company®
Loyal American Life Insurance Company®
Provident American Life and Health Insurance Company
United Teacher Associates Insurance Company



PV Case #: _____

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

(Please select Company below)

Loyal American Life Insurance Company® – P. O. Box 559015-Austin, TX 78755-9015

OE GI Underwritten Disabled (underage) New Business Reinstatement Benefit Change

Requested Medicare Supplement Effective Date: _____

SECTION I – APPLICANT INFORMATION (PRINT)

Last	Name of Applicant			Date of Birth		
	First	Middle Initial		Month	Day	Year

Age	Social Security No.	Gender	
	- -	<input type="checkbox"/> Male	<input type="checkbox"/> Female

Resident Street Address (No P. O. Box)	City	State	Zip
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Mailing Address (if different from above)	City	State	Zip
--	-------------	--------------	------------

Telephone Number () - -	E-mail Address
--	-----------------------

Medicare Card No. - -	Height Ft In	Weight Lbs
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Have you used tobacco within the last 12 months? YES NO

Rate Class: Preferred Standard

SECTION II - COVERAGE APPLIED FOR

Check plan selected (plan availability varies by company):

- Plan A Plan D Plan N
- Plan B Plan F
- Plan C Plan G

SECTION III - PREMIUM PAYMENT INFORMATION

Draft bank account for 1st premium* Check enclosed for 1st premium*

*Initial premium payment must include the one time enrollment fee.

Select payment method:

- Annual Direct or Bank Draft
- Semi-Annual Direct or Bank Draft
- Quarterly Direct or Bank Draft
- Monthly Bank Draft

One Time Enrollment Fee: \$25.00 Modal Premium: \$ _____

Amount Enclosed: \$ _____

MAKE CHECKS PAYABLE TO THE INSURANCE COMPANY.

SECTION IV – OPEN ENROLLMENT/GUARANTEED ISSUE QUESTIONS (MUST BE COMPLETED)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. **Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.** (Please mark YES or NO below with an "X".)

- | | YES | NO |
|--|--------------------------|--------------------------|
| To the best of your knowledge, | | |
| 1. (a) Did you turn age 65 in the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Did you enroll in Medicare Part B in the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "YES", what is the effective date? _____. | | |
| 2. Are you covered for medical assistance through the state Medicaid program? | <input type="checkbox"/> | <input type="checkbox"/> |
| (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.) | | |
| If "YES": | | |
| (a) Will Medicaid pay your premiums for this Medicare supplement policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days? (for example, A Medicare Advantage plan, or a Medicare HMO or PPO) | <input type="checkbox"/> | <input type="checkbox"/> |
| If "YES" | | |
| (a) Fill in your START and END dates below. If you are still covered under this plan, leave "END" date blank.
START ____/____/____ END ____/____/____ | | |
| (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Was this your first time in this type of Medicare plan? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. (a) Do you have another Medicare supplement policy in force? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) If so, with what company and what type plan do you have? _____ | | |
| _____ | | |
| (c) If so, do you intend to replace your current Medicare supplement policy with this policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| If existing Medicare supplement coverage is not to be replaced, this policy cannot be issued. | | |
| 5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan) | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) If so, with what company and what kind of policy? _____ | | |
| _____ | | |
| (b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" date blank. START ____/____/____ END ____/____/____ | | |

SECTION V – MEDICARE

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Do you now have Medicare Parts A and B? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, give effective date of Part B: _____ | | |
| 2. If Medicare Parts A and B are to be effective at a future date, provide the date both Medicare Parts A and B will be effective _____. | | |

NOTE: Medicare effective date is always the 1st day of the month. Applicant must have both Medicare Parts A & B on the effective date of the policy. If not, coverage cannot be issued.

SECTION VI - MEDICAL QUESTIONS

**IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEE ISSUE
(BASED ON YOUR ANSWERS IN SECTION IV), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.**

If the answer to any question in this section is YES the Applicant is not eligible for coverage.

- | | | |
|---|--------------------------|--------------------------|
| 1. Are you currently confined or scheduled for admission to a hospital, nursing facility, or assisted living facility, or are you receiving home health care services? | YES | NO |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you require or receive any assistance with any of your activities of daily living such as bathing, transferring, toileting, eating, dressing or continence? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently bedridden or do you use the assistance of a wheelchair, walker or motorized mobility aid?... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Within the past two (2) years have you: | | |
| a. Been hospitalized more than 2 times or received home health care services more than 3 times? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been confined to a nursing facility for more than 30 days? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been diagnosed with, treated for, or taken medication for Angina, Heart Attack, Heart or Heart Valve Surgery, Implantation of Cardiac Pacemaker or Defibrillator, Cardiomyopathy, Congestive Heart Failure, Cardiac or Vascular Angioplasty, Stent Placement, Peripheral Vascular Disease, Bypass, Endarterectomy, Carotid Artery Disease, Coronary Artery Disease or Heart Disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had a Stroke or Transient Ischemic Attack (TIA)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have now, or in the last two (2) years have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions: | | |
| a. Hepatitis, Cirrhosis of the Liver or Other Liver Disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Major Depression, Bi-Polar Disorder, Schizophrenia or a Paranoid Disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Insulin Dependent Diabetes, Diabetes with Neuropathy, Retinopathy or Vascular Disease; Chronic Kidney Disease, Addison's Disease, Renal Insufficiency, Renal Failure, or any Kidney Disease requiring dialysis, or any condition requiring an organ transplant? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease or Lymphoma? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Alcohol or Drug Abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Paralysis, Hemophilia, Osteoporosis with fractures, or un-repaired Aneurysm? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Paget's Disease, Rheumatoid or Disabling Arthritis, Lupus or other Connective tissue disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have now, or at any time have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions: | | |
| a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Cerebral Palsy, Dementia, Senility, Alzheimer's Disease or Organic Brain Disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic Obstructive Lung Disease (COLD) excluding Asthma? Or any Lung or respiratory disorder requiring the use of oxygen?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Amputation caused by disease or organ transplant other than corneas? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have now, or in the last three (3) years have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for Anemia requiring repeated blood transfusions, any other blood disorder, or disorder of the pancreas? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has surgery been advised but not performed or any surgery anticipated, including cataract surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have medical tests, treatment, or therapy been advised but not performed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Please list any prescription or any over-the-counter medications you have taken within the past 12 months. | | |

Medication	Dates Taken	Condition Taken For

NOTE: Please attach a separate sheet if needed.

SECTION VII - COMMENTS

SECTION VIII – IMPORTANT STATEMENTS FOR APPLICANT TO READ

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I hereby apply to the company indicated on page 1 of this Application for insurance (“the Company”) for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) No agent has the authority to waive the answer to any questions on the application; (2) no insurance will be effective until a policy has been issued by the Company; and (3) I have received the Outline of Medicare Supplement Coverage for the policy applied for and the required *Guide to Health Insurance for People with Medicare*.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to the fines and confinement in prison.

CAUTION: Please review your answers to the questions on the application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

A recorded telephone interview may be used as part of the underwriting on your application for insurance.

Telephone Number: (_____) _____

Best Time to Call: _____

Applicant’s Printed Name

Signature of Applicant

Date

SECTION IX - AGENT'S CERTIFICATION

Agents shall list any health insurance policies they have sold to the applicant.

1. List policies sold which are still in force. (If this does not apply, state NONE)

2. List policies sold in the past five (5) years which are no longer in force. (If this does not apply, state NONE)

3. Have you reviewed the Application for correctness and omissions? YES NO

4. I certify that I have provided the Applicant with the following documents:

- | | |
|---|---|
| (a) Application Packet (Phone Sale Only) | (c) Outline of Medicare Supplement Coverage |
| (b) <i>A Guide to Health Insurance for People with Medicare</i> | (d) Other: _____ |

I further certify that I have delivered the documents to the Applicant (check all that apply, must select at least one):

- | | |
|---|--|
| <input type="checkbox"/> In Person _____
(Date) | <input type="checkbox"/> By Mail _____
(Date) |
| <input type="checkbox"/> Email _____
(Date) | <input type="checkbox"/> Fax: _____
(Date) |
| <input type="checkbox"/> Other (Explain): _____
(Date) | |

- | | | |
|--|--------------------------|--------------------------|
| 5. Was the Application completed by you in the Applicant's physical presence? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Was the Application completed by you over the phone? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have knowledge or reason to believe the replacement of existing insurance may be involved?.. | <input type="checkbox"/> | <input type="checkbox"/> |
- If "YES" give Name of Company, reason and termination date _____
- _____
- _____

I certify that I have interviewed the Applicant, asked all of the questions as written on the Application, and I have truly and accurately recorded on the Application the information supplied to me by the Applicant.

_____ Printed Name of 1 st Licensed Agent	_____ Signature of 1 st Licensed Agent	_____ Writing Number	_____ Percentage
_____ Printed Name of 2 nd Licensed Agent	_____ Signature of 2 nd Licensed Agent	_____ Writing Number	_____ Percentage

**MEDICARE SUPPLEMENT INSURANCE PRE-AUTHORIZATION AGREEMENT
FOR ELECTRONIC FUNDS TRANSFER APPLIES TO**

(must select one below):

LOYAL AMERICAN LIFE INSURANCE COMPANY® - P. O. Box 559015 – Austin, TX 78755-9015

Proposed Insured's Name _____ Policy Number (if Available) _____

Financial Institution Name and Telephone Number _____

Financial Institution Address _____

9 Digit Routing Number _____ Account Number _____

Requested Withdrawal Date (1st thru 28th): _____

Withdraw Payment: Monthly Quarterly Semi-Annually Annually

Type of Account:

- Personal Checking Account
- Personal Savings Account
- Corporate/Business Checking

Name of Employer Group _____

Purpose for Submitting this Authorization – Check appropriate box(es):

- New authorization
- Change in checking/savings account
- Change in financial institution
- Change in existing coverage

For Checking Account:
Please tape a VOIDED check in this box.

For Savings Account:
Please attach a letter from the bank stating the account and routing number of your savings account.

TAPE VOIDED CHECK HERE 0101

PAY TO THE ORDER OF _____ \$ _____ Dollars

The Routing number is 9 digits between the **⑆** **⑆** symbols.

The Account number is usually to the left of **⑆**. If check number is left of account number, ignore check number.

The Check number should match the upper right corner.

⑆ 123456789 ⑆

34567890 ⑆

0101

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to the Company selected above provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR THE COMPANY SELECTED ABOVE: It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract, and no other notice of premiums due will be given. No premium shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium payment has been received by the selected company above. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by the selected company above if any draft is not paid upon presentation. The payment of premiums under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by the company selected above upon 30 days written notice.

Name of Payor (if other than Insured) _____ Payor's Address _____

Print Name of Depositor (as it appears on account) _____ Signature of Depositor _____ Date _____



AUTHORIZATION FORM FOR DISCLOSURES OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean:

<input type="checkbox"/> Great American Life Insurance Company®	<input checked="" type="checkbox"/> Loyal American Life Insurance Company®
<input type="checkbox"/> United Teacher Associates Insurance Company	<input type="checkbox"/> Central Reserve Life Insurance Company
<input type="checkbox"/> Provident American Life & Health Insurance Company	<input type="checkbox"/> Continental General Insurance Company
2. I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, the U.S. Veterans Administration and Selective Service System, insurance company, the Medical Information Bureau, or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents and premium accounting representatives any such records or information.
3. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
4. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Officer at P.O. Box 26580, Austin, Texas 78755-0580.
5. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
6. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
8. If you are the representative of an applicant, describe the scope of your authority to act on the applicant's behalf:

Applicant's Name

Name of applicant's personal representative, if applicable

Applicant's Social Security Number

Relationship of personal representative to the applicant

Signature of applicant

Date

Signature of personal representative

Date

Signature of Company's Agent

Date

A signed copy of this form will be provided with the policy if issued and any other time upon request.

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the applicant and by the agent, and submitted to the Company selected below with the application. A copy of this form must also be left with the applicant.

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF
MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE**

MEDICARE SUPPLEMENT INSURANCE REPLACEMENT NOTICE APPLIES TO (must select one below):

LOYAL AMERICAN LIFE INSURANCE COMPANY® - P. O. Box 559015 – Austin, TX 78755-9015

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

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by the Company selected above. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT OR BROKER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement coverage is being purchased for the following reason (check one):

- | | |
|---|---|
| <input type="checkbox"/> Additional benefits. | <input type="checkbox"/> My plan has outpatient drug coverage and I am enrolling in Part D. |
| <input type="checkbox"/> No change in benefits, but lower premiums. | <input type="checkbox"/> Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment. _____ |
| <input type="checkbox"/> Fewer benefits and lower premiums. | <input type="checkbox"/> Other, (please specify) _____. |

- (1) **NOTE:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
- (3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

**DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE
RECEIVED YOUR NEW POLICY AND ARE SURE YOU WANT TO KEEP IT.**

Agent's Signature

Applicant's Signature

Type or Print Name and Address of Agent or Broker

Date

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the applicant and by the agent, and submitted to the Company selected below with the application. A copy of this form must also be left with the applicant.

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I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement coverage is being purchased for the following reason (check one):

- Additional benefits.
- My plan has outpatient drug coverage and I am enrolling in Part D.
- No change in benefits, but lower premiums.
- Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment. _____
- Fewer benefits and lower premiums.
- Other, (please specify) _____.

- (1) **NOTE:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
- (3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

**DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE
RECEIVED YOUR NEW POLICY AND ARE SURE YOU WANT TO KEEP IT.**

Agent's Signature

Applicant's Signature

Type or Print Name and Address of Agent or Broker

Date