Gerber Life
Insurance Company

APPLICATION for
MEDICARE SUPPLEMENT INSURANCE

MICHIGAN

Gerber Life Insurance Company

2012 Medicare Supplement Insurance Plans

Your Choice

Medicare pays some of your hospital and medical expenses, but not all of them. A Medicare supplemental insurance plan from Gerber Life Insurance Company may help lower your share of the costs. Plus it can pay for additional benefits that Medicare doesn't cover at all.

You Choose:

- Your doctors and specialists
- Where you want to receive care or treatment anywhere in the U.S.
- The plan that provides the benefits you need

Choose Gerber Life Today

Policy Forms MTG20-Plan A, MTG22-Plan C, MTG24-Plan F, MTG25-Plan G

SUPPLEMENT Your Medicare Coverage

Your Gerber Life Insurance Company Medicare supplement insurance policy helps pay some eligible expenses not paid for by Medicare Part A and Medicare Part B. **There may be charges above what Medicare and your policy pay.**

Medicare Part A Hospital Coverage

Deductible – Plans C, F and G pay the $1,156 inpatient hospital deductible for each benefit period.

First 60 Days – After the Medicare Part A deductible, Medicare pays all eligible expenses for services from your first through 60th day of hospital confinement. Services include semiprivate room and board, general nursing, and miscellaneous hospital services and supplies.

Coinsurance – Plans A, C, F and G pay $289 a day when you are hospitalized from the 61st through the 90th day. And, when you are in the hospital from the 91st day through the 150th day, you receive $578 a day for each Lifetime Reserve day used.

Extended Hospital Coverage – When you are in the hospital longer than 150 days during a benefit period, and you have exhausted your 60 days of Medicare Lifetime Reserve, Plans A, C, F and G pay the Medicare Part A eligible expenses for hospitalization, paid at the rate Medicare would have paid, subject to a lifetime maximum benefit of an additional 365 days.

Benefit for Blood – Medicare has one calendar-year deductible for blood that is the cost of the first three pints needed. Plans A, C, F and G pay this deductible.

Skilled Nursing Facility Care

First 20 Days – Medicare pays all eligible expenses.

Coinsurance – Plans C, F and G pay up to $144.50 a day from the 21st through the 100th day during which you receive skilled nursing care. You must enter a Medicare-certified skilled nursing facility within 30 days of being hospitalized for at least three days.

Hospice Care Benefit

Outpatient Prescription Drugs – Plans A, C, F and G pay $5 per prescription for outpatient prescription drugs for pain and symptom management.

Inpatient Respite Care – Plans A, C, F and G pay 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest).

Medicare Part B Physician's Services & Supplies

Deductible – Plans C and F pay the $140 calendar-year deductible.

Coinsurance – After the Medicare Part B deductible, Plans A, C, F and G pay 20% of eligible expenses for physician's services and supplies, physical and speech therapy, and ambulance service.

For hospital outpatient services, the copayment amount will be paid under a prospective payment system. If this system is not used, then 20% of eligible expenses will be paid.

Excess Benefits – Your bill for Medicare Part B services and supplies may exceed the Medicare eligible expense. When that occurs, Plans F and G pay 100% of the difference, up to the charge limitation established by Medicare.

Benefit for Blood – Medicare has one calendar-year deductible for blood that is the cost of the first three pints needed. Plans A, C, F and G pay this deductible.

Additional Benefit

Emergency Care Received Outside the U.S. – After you pay a $250 calendar-year deductible, Plans C, F and G pay you 80% of eligible expenses for care beginning during the first 60 days of each trip up to a lifetime maximum of $50,000. Benefits are payable for health care you need because of a covered injury or illness.

Plan Highlights

Your policy is guaranteed renewable. It cannot be canceled. It will be renewed as long as the premiums are paid on time and the information on your application is correct.

Your Medicare supplement benefits will automatically increase as Medicare deductibles and coinsurance increase. Benefits are not paid for any expense paid by Medicare.

Benefits are paid to you or to your hospital or doctor.

You have 31 days from your renewal date to pay your premium. Your policy will stay in force during this 31-day grace period.

You cannot be singled out for a rate increase, no matter how many times you receive benefits. Your premium changes when the same premium change is made on all in-force Medicare supplement policies of the same form issued to persons of your classification in the same geographic area of your state.

Your coverage begins immediately. There is no waiting period for preexisting conditions. Benefits will be paid from the time your policy is in force.

Definitions

Medicare Part A eligible expenses for hospital/skilled nursing facility care include expenses for semiprivate room and board, general nursing and miscellaneous services and supplies.

Medicare Part B eligible expenses for medical services include expenses for physicians' services, hospital outpatient services and supplies, physical and speech therapy and ambulance service.

Medicare eligible expenses are expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

A benefit period begins the first full day you are hospitalized and ends when you have not been in a hospital or skilled nursing facility for 60 days in a row.

Coinsurance is the portion of the eligible expense not paid by Medicare and paid by Gerber Life.

Exclusions and Limitations

Your Medicare supplement insurance policy will not pay for:

- any expense incurred before your Policy Date
- hospital or skilled nursing facility confinement incurred during a Medicare Part A benefit period that begins while this policy is not in force
- expense paid for by Medicare
- services for non-Medicare eligible expenses
- services for which no charge is made when there is no insurance
- loss or expense that is payable under any other Medicare supplement insurance policy or certificate

Your Gerber Life
Medicare Supplement Choices *At a Glance*

Your Plan Choices

Whether you need a little or a lot of coverage, we have a Medicare supplement that meets your needs and budget. Please refer to the previous pages and your outline of coverage for details.

Every plan includes these basic benefits:

- Hospitalization: Medicare Part A coinsurance and coverage for 365 additional days after Medicare benefits end
- Hospice Care: Outpatient prescription drug co-payment and inpatient respite care coinsurance
- Medical Expenses: Medicare Part B coinsurance (generally 20%)
- Three pints of blood each year

	Plan A	Plan C	Plan F	Plan G
Basic Benefits	✓	✓	✓	✓
Skilled Nursing Coinsurance		✓	✓	✓
Medicare Part A Deductible		✓	✓	✓
Medicare Part B Deductible		✓	✓	
Medicare Part B Excess			✓	✓
Foreign Travel Emergency		✓	✓	✓

This is a brief description of your coverage. The outline of coverage must accompany this brochure. For complete information on benefits, exceptions, reductions and limitations, please read your outline of coverage and your policy.

This is a solicitation of insurance and an agent will contact you by telephone.

Neither Gerber Life Insurance Company nor its Medicare supplement insurance policies are connected with or endorsed by the U.S. government or the federal Medicare program.

Meet Gerber Life Insurance Company

Since 1967, Gerber Life Insurance Company has provided quality life insurance, especially for young families on a limited budget. As an affiliate of the Gerber Products Company, "the baby food people," the two companies share a common goal: to help parents raise happy, healthy children.

It is also our mission to be the company parents and grandparents trust to help them achieve financial security and protection at every stage of life. By providing affordable, industry-leading juvenile life insurance, and life, accident and Medicare supplement insurance for adults, we strive to give our customers the comfort and peace of mind they deserve.

Gerber Life Insurance Company

Medicare supplement insurance is underwritten by:
Gerber Life Insurance Company • 1311 Mamaroneck Avenue • White Plains, NY 10605

"We're with you every step of the way."

GERBER LIFE INSURANCE COMPANY

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE — COVER PAGE

BENEFIT PLANS A, C, F AND G

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state. See Outlines of Coverage sections for details about ALL plans.

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
Blood: First 3 pints of blood each year.
Hospice: Part A coinsurance.

A	B	**C**	D	**F** / F*	**G**
Basic, includ-ing 100% Part B co-insur-ance	Basic, including 100% Part B co-insurance	**Basic, including 100% Part B co-insurance**	Basic, including 100% Part B co-insurance	**Basic, including 100% Part B co-insurance ***	**Basic, including 100% Part B co-insurance**
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	**Skilled Nursing Facility Co-insurance**	**Skilled Nursing Facility Co-insurance**
	Part A Deductible	**Part A Deductible**	Part A Deductible	**Part A Deductible**	**Part A Deductible**
		Part B Deductible		**Part B Deductible**	
				Part B Excess (100%)	**Part B Excess (100%)**
		Foreign Travel Emer-gency	Foreign Travel Emer-gency	**Foreign Travel Emer-gency**	**Foreign Travel Emer-gency**

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B co-insurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $4,660; paid at 100% after limit reached	Out-of-pocket limit $2,330; paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy/certificate. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plans' separate foreign travel emergency deductible.

MONTHLY NON-TOBACCO RATES
ZIP CODES: 490-491, 493-497, 498-499

FEMALE					MALE			
Plan A MTG20	**Plan C MTG22**	**Plan F MTG24**	**Plan G MTG25**	**Attained**	**Plan A MTG20**	**Plan C MTG22**	**Plan F MTG24**	**Plan G MTG25**
92.56	131.92	132.40	102.47	**65**	106.39	151.63	152.18	117.78
95.73	136.25	136.75	105.79	**66**	110.04	156.61	157.18	121.60
99.99	142.10	142.62	110.30	**67**	114.93	163.33	163.93	126.78
103.27	146.79	147.32	113.93	**68**	118.70	168.73	169.34	130.95
106.46	151.65	152.19	117.73	**69**	122.37	174.30	174.93	135.32
109.48	156.35	156.92	121.45	**70**	125.84	179.72	180.37	139.59
112.35	160.90	161.48	125.03	**71**	129.13	184.95	185.61	143.71
115.06	165.29	165.89	128.48	**72**	132.26	189.99	190.68	147.67
117.49	169.31	169.91	131.66	**73**	135.04	194.61	195.30	151.34
119.61	173.06	173.67	134.65	**74**	137.49	198.92	199.62	154.77
121.40	176.43	177.04	137.37	**75**	139.54	202.79	203.49	157.90
123.10	179.71	180.35	140.03	**76**	141.50	206.56	207.30	160.95
124.69	182.87	183.50	142.57	**77**	143.32	210.19	210.92	163.87
126.17	185.83	186.48	144.97	**78**	145.02	213.59	214.34	166.63
127.56	188.70	189.36	147.31	**79**	146.62	216.90	217.66	169.32
128.94	191.59	192.25	149.65	**80**	148.20	220.22	220.98	172.01
130.23	194.40	195.06	151.94	**81**	149.69	223.45	224.21	174.64
131.43	197.14	197.81	154.17	**82**	151.07	226.59	227.37	177.21
132.51	199.70	200.37	156.28	**83**	152.31	229.54	230.32	179.63
133.50	202.22	202.90	158.36	**84**	153.45	232.44	233.21	182.02
134.43	204.65	205.35	160.37	**85**	154.51	235.23	236.03	184.34
135.33	207.10	207.78	162.40	**86**	155.55	238.04	238.83	186.67
136.24	209.63	210.32	164.50	**87**	156.60	240.96	241.75	189.08
137.16	212.09	212.80	166.54	**88**	157.65	243.78	244.59	191.43
138.09	214.57	215.27	168.66	**89**	158.72	246.64	247.44	193.86
139.04	217.16	217.87	170.86	**90**	159.82	249.61	250.42	196.39
140.01	219.79	220.49	173.09	**91**	160.93	252.63	253.44	198.95
141.00	222.51	223.22	175.40	**92**	162.07	255.76	256.57	201.61
142.03	225.31	226.03	177.78	**93**	163.25	258.98	259.80	204.35
143.09	228.26	228.98	180.28	**94**	164.47	262.37	263.19	207.22
144.14	231.21	231.94	182.80	**95**	165.67	265.76	266.59	210.11
145.14	234.16	234.89	185.30	**96**	166.83	269.14	269.99	212.99
146.05	236.96	237.70	187.69	**97**	167.88	272.37	273.22	215.73
146.94	239.82	240.56	190.14	**98**	168.90	275.66	276.50	218.55
147.84	242.77	243.50	192.65	**99+**	169.93	279.04	279.88	221.44

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, and 3, respectively.

RP9.1.T03

MONTHLY TOBACCO RATES
ZIP CODES: 490-491, 493-497, 498-499

FEMALE					MALE			
Plan A MTG20	Plan C MTG22	Plan F MTG24	Plan G MTG25	Attained	Plan A MTG20	Plan C MTG22	Plan F MTG24	Plan G MTG25
106.39	151.63	152.18	117.78	**65**	122.29	174.29	174.92	135.38
110.04	156.61	157.18	121.60	**66**	126.48	180.01	180.67	139.77
114.93	163.33	163.93	126.78	**67**	132.10	187.74	188.42	145.72
118.70	168.73	169.34	130.95	**68**	136.44	193.94	194.64	150.52
122.37	174.30	174.93	135.32	**69**	140.65	200.35	201.07	155.54
125.84	179.72	180.37	139.59	**70**	144.64	206.57	207.32	160.45
129.13	184.95	185.61	143.71	**71**	148.43	212.58	213.35	165.18
132.26	189.99	190.68	147.67	**72**	152.02	218.38	219.17	169.74
135.04	194.61	195.30	151.34	**73**	155.22	223.69	224.48	173.95
137.49	198.92	199.62	154.77	**74**	158.03	228.64	229.45	177.90
139.54	202.79	203.49	157.90	**75**	160.39	233.09	233.90	181.49
141.50	206.56	207.30	160.95	**76**	162.64	237.43	238.27	185.00
143.32	210.19	210.92	163.87	**77**	164.74	241.60	242.44	188.36
145.02	213.59	214.34	166.63	**78**	166.69	245.51	246.37	191.53
146.62	216.90	217.66	169.32	**79**	168.53	249.31	250.18	194.62
148.20	220.22	220.98	172.01	**80**	170.35	253.13	254.00	197.71
149.69	223.45	224.21	174.64	**81**	172.06	256.84	257.71	200.74
151.07	226.59	227.37	177.21	**82**	173.64	260.45	261.34	203.69
152.31	229.54	230.32	179.63	**83**	175.07	263.84	264.73	206.47
153.45	232.44	233.21	182.02	**84**	176.38	267.17	268.06	209.22
154.51	235.23	236.03	184.34	**85**	177.60	270.38	271.30	211.88
155.55	238.04	238.83	186.67	**86**	178.79	273.61	274.52	214.56
156.60	240.96	241.75	189.08	**87**	180.00	276.96	277.87	217.33
157.65	243.78	244.59	191.43	**88**	181.21	280.21	281.14	220.03
158.72	246.64	247.44	193.86	**89**	182.44	283.49	284.41	222.83
159.82	249.61	250.42	196.39	**90**	183.70	286.91	287.84	225.74
160.93	252.63	253.44	198.95	**91**	184.98	290.38	291.31	228.68
162.07	255.76	256.57	201.61	**92**	186.29	293.98	294.91	231.74
163.25	258.98	259.80	204.35	**93**	187.64	297.68	298.62	234.88
164.47	262.37	263.19	207.22	**94**	189.05	301.57	302.52	238.18
165.67	265.76	266.59	210.11	**95**	190.43	305.47	306.43	241.51
166.83	269.14	269.99	212.99	**96**	191.76	309.36	310.33	244.82
167.88	272.37	273.22	215.73	**97**	192.96	313.07	314.04	247.97
168.90	275.66	276.50	218.55	**98**	194.14	316.85	317.82	251.21
169.93	279.04	279.88	221.44	**99+**	195.32	320.74	321.70	254.53

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, and 3, respectively.

RP9.1.T03

MONTHLY NON-TOBACCO RATES
ZIP CODES: 486-489, 492

FEMALE					MALE			
Plan A MTG20	Plan C MTG22	Plan F MTG24	Plan G MTG25	Attained	Plan A MTG20	Plan C MTG22	Plan F MTG24	Plan G MTG25
109.22	155.67	156.23	120.91	**65**	125.54	178.93	179.57	138.98
112.96	160.77	161.36	124.84	**66**	129.85	184.80	185.48	143.49
117.98	167.68	168.29	130.15	**67**	135.61	192.73	193.43	149.60
121.86	173.22	173.84	134.44	**68**	140.07	199.10	199.82	154.52
125.62	178.94	179.58	138.92	**69**	144.39	205.68	206.42	159.68
129.18	184.50	185.17	143.31	**70**	148.49	212.07	212.84	164.72
132.57	189.86	190.55	147.53	**71**	152.38	218.23	219.03	169.57
135.78	195.04	195.75	151.60	**72**	156.06	224.19	225.00	174.26
138.63	199.79	200.49	155.36	**73**	159.35	229.64	230.45	178.58
141.14	204.21	204.93	158.89	**74**	162.23	234.72	235.55	182.63
143.25	208.18	208.91	162.10	**75**	164.66	239.29	240.12	186.32
145.26	212.06	212.81	165.23	**76**	166.97	243.75	244.61	189.92
147.14	215.78	216.53	168.23	**77**	169.12	248.03	248.89	193.37
148.88	219.28	220.04	171.06	**78**	171.12	252.04	252.92	196.62
150.52	222.67	223.45	173.82	**79**	173.01	255.94	256.84	199.80
152.15	226.08	226.86	176.58	**80**	174.88	259.86	260.76	202.97
153.68	229.39	230.17	179.29	**81**	176.64	263.67	264.57	206.08
155.09	232.62	233.41	181.92	**82**	178.26	267.38	268.29	209.11
156.36	235.65	236.44	184.41	**83**	179.73	270.86	271.77	211.96
157.53	238.62	239.42	186.86	**84**	181.07	274.28	275.19	214.79
158.62	241.49	242.31	189.24	**85**	182.32	277.57	278.52	217.52
159.69	244.37	245.19	191.63	**86**	183.55	280.89	281.82	220.27
160.77	247.36	248.18	194.11	**87**	184.79	284.33	285.26	223.11
161.85	250.27	251.10	196.52	**88**	186.03	287.66	288.62	225.88
162.94	253.20	254.02	199.02	**89**	187.29	291.03	291.98	228.76
164.07	256.25	257.08	201.62	**90**	188.59	294.54	295.50	231.75
165.21	259.35	260.18	204.24	**91**	189.90	298.10	299.06	234.76
166.38	262.57	263.40	206.98	**92**	191.25	301.80	302.76	237.90
167.59	265.87	266.71	209.78	**93**	192.63	305.60	306.56	241.13
168.85	269.35	270.19	212.73	**94**	194.08	309.59	310.57	244.52
170.08	272.83	273.69	215.70	**95**	195.50	313.60	314.58	247.93
171.27	276.30	277.17	218.66	**96**	196.86	317.59	318.58	251.33
172.34	279.62	280.48	221.47	**97**	198.09	321.40	322.39	254.57
173.40	282.99	283.86	224.37	**98**	199.30	325.28	326.27	257.89
174.45	286.47	287.32	227.33	**99+**	200.52	329.27	330.26	261.30

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, and 3, respectively.

RP9.1.T03

MONTHLY TOBACCO RATES
ZIP CODES: 486-489, 492

FEMALE					MALE			
Plan A MTG20	Plan C MTG22	Plan F MTG24	Plan G MTG25	Attained	Plan A MTG20	Plan C MTG22	Plan F MTG24	Plan G MTG25
125.54	178.93	179.57	138.98	**65**	144.30	205.66	206.41	159.75
129.84	184.80	185.48	143.49	**66**	149.25	212.41	213.19	164.93
135.61	192.73	193.43	149.60	**67**	155.88	221.53	222.34	171.95
140.07	199.10	199.82	154.52	**68**	161.00	228.85	229.68	177.61
144.39	205.68	206.42	159.68	**69**	165.97	236.41	237.26	183.54
148.49	212.07	212.84	164.72	**70**	170.68	243.75	244.64	189.33
152.38	218.24	219.03	169.57	**71**	175.15	250.84	251.75	194.91
156.06	224.19	225.00	174.26	**72**	179.38	257.69	258.62	200.29
159.35	229.64	230.45	178.58	**73**	183.16	263.95	264.89	205.26
162.23	234.72	235.55	182.63	**74**	186.48	269.80	270.75	209.92
164.66	239.29	240.12	186.32	**75**	189.26	275.05	276.00	214.16
166.97	243.75	244.61	189.92	**76**	191.92	280.17	281.16	218.30
169.12	248.03	248.89	193.37	**77**	194.39	285.09	286.08	222.27
171.12	252.04	252.92	196.62	**78**	196.69	289.70	290.72	226.01
173.01	255.94	256.84	199.80	**79**	198.87	294.19	295.21	229.65
174.88	259.86	260.76	202.97	**80**	201.01	298.69	299.72	233.30
176.64	263.67	264.57	206.08	**81**	203.03	303.07	304.10	236.87
178.26	267.38	268.29	209.11	**82**	204.90	307.33	308.38	240.35
179.73	270.86	271.77	211.96	**83**	206.58	311.33	312.38	243.64
181.07	274.28	275.19	214.79	**84**	208.13	315.26	316.31	246.88
182.32	277.57	278.52	217.52	**85**	209.57	319.05	320.13	250.02
183.55	280.89	281.82	220.27	**86**	210.97	322.86	323.93	253.18
184.79	284.33	285.26	223.11	**87**	212.40	326.81	327.89	256.45
186.03	287.66	288.62	225.88	**88**	213.83	330.65	331.75	259.64
187.29	291.03	291.98	228.76	**89**	215.28	334.52	335.60	262.94
188.59	294.54	295.50	231.75	**90**	216.77	338.55	339.65	266.37
189.90	298.10	299.06	234.76	**91**	218.28	342.65	343.75	269.84
191.25	301.80	302.75	237.91	**92**	219.82	346.90	347.99	273.45
192.63	305.60	306.56	241.13	**93**	221.42	351.26	352.37	277.16
194.08	309.59	310.57	244.52	**94**	223.08	355.85	356.97	281.05
195.50	313.60	314.58	247.93	**95**	224.71	360.46	361.59	284.98
196.86	317.59	318.59	251.33	**96**	226.28	365.05	366.19	288.89
198.09	321.40	322.39	254.57	**97**	227.69	369.42	370.57	292.61
199.30	325.28	326.27	257.89	**98**	229.09	373.88	375.03	296.43
200.52	329.27	330.26	261.30	**99+**	230.48	378.47	379.61	300.35

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, and 3, respectively.

RP9.1.T03

MONTHLY NON-TOBACCO RATES
ZIP CODES: 480-485

FEMALE					MALE			
Plan A MTG20	Plan C MTG22	Plan F MTG24	Plan G MTG25	Attained	Plan A MTG20	Plan C MTG22	Plan F MTG24	Plan G MTG25
128.66	183.37	184.03	142.43	**65**	147.89	210.77	211.53	163.72
133.07	189.39	190.08	147.05	**66**	152.95	217.69	218.48	169.02
138.98	197.52	198.23	153.31	**67**	159.75	227.03	227.86	176.22
143.55	204.04	204.78	158.36	**68**	165.00	234.53	235.38	182.02
147.98	210.79	211.54	163.64	**69**	170.09	242.28	243.15	188.10
152.18	217.33	218.12	168.81	**70**	174.91	249.81	250.71	194.03
156.16	223.65	224.46	173.79	**71**	179.50	257.07	258.00	199.75
159.94	229.76	230.59	178.58	**72**	183.84	264.09	265.04	205.27
163.31	235.34	236.17	183.01	**73**	187.71	270.51	271.46	210.36
166.26	240.55	241.40	187.17	**74**	191.11	276.50	277.47	215.13
168.74	245.23	246.08	190.95	**75**	193.96	281.88	282.86	219.48
171.11	249.80	250.68	194.64	**76**	196.68	287.12	288.14	223.72
173.32	254.19	255.07	198.17	**77**	199.22	292.17	293.18	227.78
175.37	258.30	259.20	201.51	**78**	201.58	296.90	297.94	231.62
177.31	262.30	263.21	204.76	**79**	203.80	301.49	302.54	235.35
179.22	266.32	267.23	208.01	**80**	206.00	306.11	307.16	239.09
181.02	270.22	271.13	211.20	**81**	208.07	310.60	311.65	242.76
182.69	274.02	274.95	214.30	**82**	209.98	314.96	316.04	246.32
184.19	277.58	278.52	217.23	**83**	211.71	319.06	320.14	249.68
185.57	281.09	282.02	220.12	**84**	213.30	323.09	324.17	253.01
186.85	284.47	285.43	222.92	**85**	214.77	326.97	328.08	256.23
188.10	287.86	288.82	225.74	**86**	216.21	330.88	331.98	259.47
189.38	291.39	292.34	228.65	**87**	217.67	334.93	336.03	262.82
190.65	294.81	295.79	231.49	**88**	219.14	338.86	339.98	266.08
191.94	298.26	299.23	234.44	**89**	220.63	342.82	343.94	269.47
193.27	301.86	302.83	237.50	**90**	222.15	346.96	348.09	272.99
194.62	305.51	306.49	240.59	**91**	223.70	351.16	352.28	276.54
195.99	309.29	310.27	243.81	**92**	225.28	355.51	356.64	280.24
197.41	313.19	314.18	247.12	**93**	226.91	359.98	361.12	284.04
198.90	317.28	318.28	250.59	**94**	228.62	364.69	365.84	288.03
200.35	321.38	322.39	254.09	**95**	230.29	369.41	370.57	292.06
201.75	325.48	326.50	257.57	**96**	231.90	374.11	375.28	296.06
203.01	329.38	330.40	260.89	**97**	233.35	378.60	379.77	299.87
204.25	333.35	334.38	264.30	**98**	234.77	383.17	384.34	303.79
205.49	337.45	338.46	267.79	**99+**	236.20	387.87	389.03	307.80

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, and 3, respectively.

RP9.1.T03

MONTHLY TOBACCO RATES
ZIP CODES: 480-485

FEMALE					MALE			
Plan A MTG20	Plan C MTG22	Plan F MTG24	Plan G MTG25	Attained	Plan A MTG20	Plan C MTG22	Plan F MTG24	Plan G MTG25
147.89	210.77	211.53	163.72	**65**	169.98	242.26	243.14	188.18
152.95	217.69	218.48	169.02	**66**	175.81	250.21	251.13	194.28
159.75	227.03	227.86	176.22	**67**	183.62	260.96	261.90	202.55
165.00	234.53	235.38	182.02	**68**	189.65	269.58	270.55	209.22
170.09	242.28	243.15	188.10	**69**	195.50	278.49	279.49	216.20
174.91	249.81	250.71	194.03	**70**	201.05	287.13	288.18	223.03
179.50	257.07	258.00	199.75	**71**	206.32	295.49	296.56	229.60
183.84	264.09	265.04	205.27	**72**	211.31	303.55	304.65	235.94
187.71	270.51	271.46	210.36	**73**	215.76	310.93	312.03	241.79
191.11	276.49	277.47	215.14	**74**	219.66	317.81	318.94	247.28
193.96	281.88	282.86	219.48	**75**	222.94	324.00	325.12	252.27
196.68	287.12	288.14	223.72	**76**	226.07	330.03	331.20	257.15
199.22	292.17	293.18	227.78	**77**	228.99	335.82	336.99	261.82
201.58	296.90	297.94	231.62	**78**	231.70	341.26	342.45	266.23
203.80	301.49	302.54	235.35	**79**	234.26	346.54	347.75	270.52
206.00	306.11	307.16	239.09	**80**	236.79	351.85	353.06	274.82
208.07	310.60	311.65	242.76	**81**	239.16	357.01	358.22	279.03
209.98	314.96	316.04	246.32	**82**	241.36	362.03	363.26	283.13
211.71	319.06	320.14	249.68	**83**	243.35	366.74	367.98	286.99
213.30	323.09	324.17	253.01	**84**	245.17	371.37	372.60	290.82
214.77	326.97	328.08	256.23	**85**	246.86	375.83	377.11	294.51
216.21	330.88	331.98	259.47	**86**	248.52	380.32	381.58	298.24
217.67	334.93	336.03	262.82	**87**	250.20	384.97	386.24	302.09
219.14	338.86	339.98	266.08	**88**	251.88	389.49	390.79	305.84
220.62	342.83	343.94	269.47	**89**	253.59	394.05	395.33	309.73
222.15	346.96	348.09	272.99	**90**	255.34	398.81	400.10	313.78
223.70	351.16	352.28	276.54	**91**	257.12	403.63	404.92	317.87
225.28	355.51	356.64	280.24	**92**	258.94	408.63	409.93	322.12
226.91	359.98	361.12	284.04	**93**	260.82	413.78	415.08	326.48
228.62	364.69	365.84	288.03	**94**	262.78	419.18	420.50	331.07
230.29	369.41	370.57	292.06	**95**	264.70	424.60	425.94	335.70
231.90	374.11	375.28	296.06	**96**	266.55	430.01	431.36	340.30
233.35	378.60	379.77	299.87	**97**	268.21	435.17	436.52	344.68
234.77	383.17	384.34	303.79	**98**	269.86	440.42	441.77	349.18
236.20	387.87	389.03	307.80	**99+**	271.50	445.83	447.16	353.80

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, and 3, respectively.

RP9.1.T03

Disclosures
Use this outline to compare benefits and premiums among policies.

Premium Information
We, Gerber Life, can only raise your premium if we raise the premium for all the policies like yours in the same geographic area of the state where you live. Until you are age 99, your premium may change each year. This change will only be made on the first renewal date that coincides with or follows each anniversary of the policy date. Schedules of rates may vary depending upon your policy date.

There will be a one-time enrollment fee of $25.00 added to the first premium.

Read Your Policy Very Carefully
This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right to Return Policy
If you find that you are not satisfied with your policy, you may return it to Gerber Life Insurance Company at our administrative office, 3316 Farnam Street, Omaha, NE 68175. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy Replacement
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice
The policy may not fully cover all of your medical costs. Neither Gerber Life nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

Complete Answers Are Very Important
When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLANS A AND C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan A Pays	You Pay	Plan C Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies					
First 60 days	All but $1,156	$0	$1,156 (Part A Deductible)	$1,156 (Part A Deductible)	$0
61st through 90th day	All but $289 a day	$289 a day	$0	$289 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $578 a day	$578 a day	$0	$578 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**	100% of Medicare Eligible Expenses	$0**
Beyond the additional 365 days	$0	$0	All costs	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.					
First 20 days	All approved amounts	$0	$0	$0	$0
21st through 100th day	All but $144.50 a day	$0	Up to $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs	$0	All costs
BLOOD					
First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy/certificate's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLANS A AND C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $140 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A Pays	You Pay	Plan C Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B Deductible)	$140 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0	All costs	$0	All costs
BLOOD First 3 pints	$0	All costs	$0	All costs	$0
Next $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B Deductible)	$140 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0

PARTS A AND B

Services	Medicare Pays	Plan A Pays	You Pay	Plan C Pays	You Pay
HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment First $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B Deductible)	$140 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0

PLANS A AND C
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

OTHER BENEFITS — NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan A Pays	You Pay	Plan C Pays	You Pay
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	N/A	All Costs	$0	$250
Remainder of charges	$0	N/A	All Costs	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit

PLANS F AND G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,156	$1,156 (Part A Deductible)	$0	$1,156 (Part A Deductible)	$0
61st through 90th day	All but $289 a day	$289 a day	$0	$289 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $578 a day	$578 a day	$0	$578 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**	100% of Medicare Eligible Expenses	$0**
Beyond the additional 365 days	$0	$0	All costs	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital. First 20 days	All approved amounts	$0	$0	$0	$0
21st through 100th day	All but $144.50 a day	Up to $144.50 a day	$0	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy/certificate's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLANS F AND G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $140 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $140 of Medicare Approved Amounts*	$0	$140 (Part B Deductible)	$0	$0	$140 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	100%	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0	All costs	$0
Next $140 of Medicare Approved Amounts*	$0	$140 (Part B Deductible)	$0	$0	$140 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0

PARTS A AND B

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment First $140 of Medicare Approved Amounts*	$0	$140 (Part B Deductible)	$0	$0	$140 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0

PLANS F AND G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

OTHER BENEFITS — NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250	$0	$250
Remainder of charges	$0	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit

Michigan

Producer Information – Please Complete

Producer Name	Agent Writing Number or Social Security Number	Commission Share	Commission Code- Required only if you are not appointed or licensed or are changing brokerage firms
______________	[ ][ ][ ][ ][ ][ ][ ][ ][ ]	[ ][ ][ ]%	[ ][ ]
______________	[ ][ ][ ][ ][ ][ ][ ][ ][ ]	[ ][ ][ ]%	[ ][ ]

Preferred Method of Communication (Select one)

☐ Phone ☐ Fax ☐ Email Contact info: ____________________

Note: Producers must be under the same commission code to share or split commissions.

Application Submission Checklist – Gerber Medicare Supplement Coverage

☐ **Provide Applicant with the Guide to Health Insurance for People with Medicare**

☐ **Provide Applicant with the Outline of Coverage**
- Calculate the premium based on age at application date
- Tobacco rates do not apply during open enrollment or guaranteed issue situations

☐ **Complete the Calculate Your Premium form (T03_626) to determine rate**

☐ **Application (complete in full)**

Sections A & B: Plan and Applicant Information
- Select plan
- Enter Requested Effective Date
- Indicate where the policy is to be mailed

Section C: Medicare Information
- Include applicant's Medicare claim number on the application. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate "eligibility" and "enrollment" dates.

Section D: Previous or Existing Coverage Information
- Please complete ALL questions in full

For Sections E and F – Refer to the Open Enrollment/Guaranteed Issue worksheet (T03_633) to help identify eligibility.

Section E: Please answer all of the following questions
- If either Applicant A or B answered "YES" to question 5 OR BOTH questions 6 and 7 in Section E, they can skip to Section H

Sections F & G: Health/Medication Information
- Do NOT answer if applicant is in an open enrollment or guaranteed issue period

Section H: Agreement and Authorization
- Make sure applicant(s) sign and date the application

Section J: To be Completed by Producer
- Make sure producer(s) sign and date the application

☐ **Complete the Method of Payment form (T03_635) and return with the completed application**
- Use premium determined by the **Calculate Your Premium form (T03_626)**
- The full modal premium is collected at the time of application

☐ **Complete Replacement Notice (T03_202) and leave a copy with the applicant (if applicable)**

☐ **Provide Applicant with Premium Receipt signed by agent (if applicable), and provide Applicant with Notice of Information Practices (T03_364)**

Note: An interviewer may call to verify/confirm the information provided on the application.
This form is required if splitting commissions.

T03_230_MI_0611

Open Enrollment and Guaranteed Issue Worksheet

If any of the following situations apply, applicant is in an open enrollment or guaranteed issue period: (Situations may vary by state and coverage may be limited. Please refer to the Underwriting Guide for more information.)

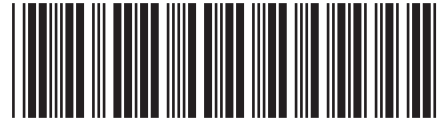
ELIGIBILITY FOR OPEN ENROLLMENT

Applicant is:

- at least 64 ½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

Note: Coverage cannot be effective until your Medicare coverage is effective.

ELIGIBILITY FOR GUARANTEED ISSUE



Evidence of eligibility is required for the following situations.
Applicant:

- is in the original Medicare plan, has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending
- is in the original Medicare plan, has a Medicare Select policy, and moves out of the Select plan's service area
- loses coverage due to their Medicare supplement insurance company's insolvency or at no fault of the applicant
- the applicant leaves their Medicare supplement plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Applicant was enrolled in a Medicare Advantage (MA) plan, and:

- the plan is leaving the Medicare program or stops service in the applicant's area, or the applicant moves out of the plan's service area (applicant must switch back to original Medicare)
- the applicant leaves the plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

- the applicant decided to switch to original Medicare within the first year of joining a MA plan when first eligible for Medicare Part A at age 65

Applicant has the right to buy any Medicare supplement plan that is sold in the applicant's state by any insurance company.

- after dropping their Medicare supplement policy to join a MA plan for the first time, has been on the MA plan less than one year and wants to switch back

Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available, buy any Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Acceptable Evidence of Eligibility:

a. Copy of the applicant's MA plan's termination notice
b. Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
c. Signed statement that the applicant has requested to be disenrolled from his/her MA plan
d. Certification of group coverage
e. Copy of the termination letter from employer or group carrier
f. Image of insurance ID card (ONLY allowed if your MA plan is being terminated)

T03_633

Gerber Life
Insurance Company

Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan **Applicant A** _______
Applicant B _______

Before you begin: *Please go to the Height and Weight Chart on the next page to determine your eligibility for coverage, unless you are in an open enrollment or guaranteed issue period.*

	Steps	Example Rate displayed is used for calculation purposes only.	Applicant A	Applicant B
#1	**Age** Write in your age at the time of signing the application. **ZIP Code** Indicate your ZIP Code used to determine your rate.	65 51502		
#2	**Premium** Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.	$128.52		
#3	**Payment Options** To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	$128.52 monthly payment $385.56 quarterly payment $771.12 semiannual payment $1,542.24 annual payment		
#4	**Enrollment/Policy Fee** There is a one-time application fee of $25.00. **This will be collected with your initial payment and will NOT affect your renewal premiums amount.**	$128.52 + $25.00 = $153.52 Example shows initial payment (monthly schedule).		

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Height and Weight Chart

Eligibility

Find your height in the left-hand column and look across the row to find your weight. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time.

	Decline	**Standard**	**Decline**
Height	Weight	Weight	Weight
4' 2''	< 54	54 – 145	146 +
4' 3''	< 56	56 – 151	152 +
4' 4''	< 58	58 – 157	158 +
4' 5''	< 60	60 – 163	164 +
4' 6''	< 63	63 – 170	171 +
4' 7''	< 65	65 – 176	177 +
4' 8''	< 67	67 – 182	183 +
4' 9''	< 70	70 – 189	190 +
4' 10''	< 72	72 – 196	197 +
4' 11''	< 75	75 – 202	203 +
5' 0''	< 77	77 – 209	210 +
5' 1''	< 80	80 – 216	217 +
5' 2''	< 83	83 – 224	225 +
5' 3''	< 85	85 – 231	232 +
5' 4''	< 88	88 – 238	239 +
5' 5''	< 91	91 – 246	247 +
5' 6''	< 93	93 – 254	255 +
5' 7''	< 96	96 – 261	262 +
5' 8''	< 99	99 – 269	270 +
5' 9''	< 102	102 – 277	278 +
5' 10''	< 105	105 – 285	286 +
5' 11''	< 108	108 – 293	294 +
6' 0''	< 111	111 – 302	303 +
6' 1''	< 114	114 – 310	311 +
6' 2''	< 117	117 – 319	320 +
6' 3''	< 121	121 – 328	329 +
6' 4''	< 124	124 – 336	337 +
6' 5''	< 127	127 – 345	346 +
6' 6''	< 130	130 – 354	355 +
6' 7''	< 134	134 – 363	364 +
6' 8''	< 137	137 – 373	374 +
6' 9''	< 140	140 – 382	383 +
6' 10''	< 144	144 – 392	393 +
6' 11''	< 147	147 – 401	402 +
7' 0''	< 151	151 – 411	412 +
7' 1''	< 155	155 – 421	422 +
7' 2''	< 158	158 – 431	432 +
7' 3''	< 162	162 – 441	442 +
7' 4''	< 166	166 – 451	452 +

Medicare supplement insurance is underwritten by
Gerber Life Insurance Company
Administrative Office
P.O. Box 2271
Omaha, Nebraska 68103-2271

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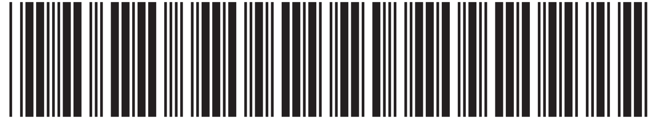
Agent Writing # | | | | | | |

FAV Key ____________



Gerber Life Insurance Company

Application for Medicare Supplement Coverage

Applicant acknowledges and agrees that if there is more than one applicant on this application, all information provided may be viewed or shared with the other applicant.

A. Plan Information (to be completed by Producer)

Applicant A	Applicant B
Plan (select one) ☐ Plan A ☐ Plan C ☐ Plan F ☐ Plan G	**Plan (select one)** ☐ Plan A ☐ Plan C ☐ Plan F ☐ Plan G
Requested Effective Date __ / __ / ____	**Requested Effective Date** __ / __ / ____
Deliver Policy to Applicant B ☐ Producer ☐	**Deliver Policy to** Applicant B ☐ Producer ☐

B. Applicant Information

Applicant A	Applicant B
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone ___ – ___ – ____ (area code)	Home Phone ___ – ___ – ____ (area code)
E-mail Address	E-mail Address
Current Age ________ Date of Birth __ / __ / ____ (mo day yr)	Current Age ________ Date of Birth __ / __ / ____ (mo day yr)
☐ Male ☐ Female	☐ Male ☐ Female
Social Security # ___ – __ – ____	Social Security # ___ – __ – ____

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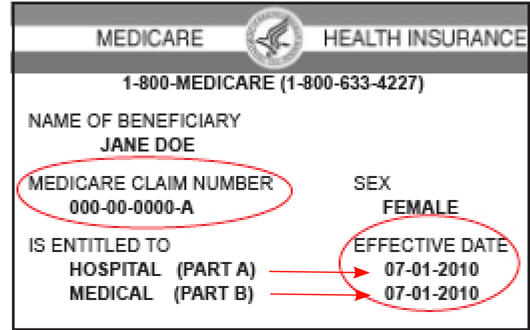
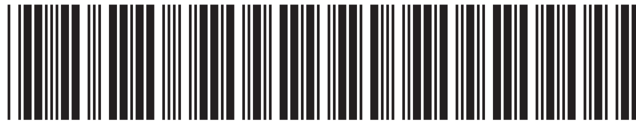
C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A	Applicant B
Medicare Claim Number	Medicare Claim Number
Medicare Part A Effective Date __ __/__ __/__ __ __ __ If you are not covered under Medicare Part A, what is your eligibility date __ __/__ __/__ __ __ __	Medicare Part A Effective Date __ __/__ __/__ __ __ __ If you are not covered under Medicare Part A, what is your eligibility date __ __/__ __/__ __ __ __
Medicare Part B Effective Date __ __/__ __/__ __ __ __ If you are not covered under Medicare Part B, indicate the date you plan to enroll __ __/__ __/__ __ __ __	Medicare Part B Effective Date __ __/__ __/__ __ __ __ If you are not covered under Medicare Part B, indicate the date you plan to enroll __ __/__ __/__ __ __ __



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D. Previous or Existing Coverage Information

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 certificate, or that you had certain rights to buy such a policy or certificate, 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" with an "X" to the questions below.

To the Best of Your Knowledge and Belief:	**Applicant A**	**Applicant B**
1. Are you covered for medical assistance through the state Medicaid program?................ (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.)	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?..................	☐ Y ☐ N	☐ Y ☐ N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?..	☐ Y ☐ N	☐ Y ☐ N

Please answer questions regarding another Medicare supplement or Select plan:

2. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?..	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?..	☐ Y ☐ N	☐ Y ☐ N

(b) Indicate planned termination or disenrollment date.............................. Applicant A __ __/__ __/__ __ __ __

Applicant B __ __/__ __/__ __ __ __

(c) With what company, and what plan do you have?

Applicant A	**Applicant B**
Name of Company	Name of Company
Plan	Plan

Please answer questions regarding Medicare plan coverage (other than Medicare supplement):

	Applicant A	**Applicant B**
3. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)......	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this previous or existing coverage:		

(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank... Applicant A START __ __/__ __/__ __ __ __

END __ __/__ __/__ __ __ __

Applicant B 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?...	☐ Y ☐ N	☐ Y ☐ N

(c) Planned date of termination/disenrollment?.. Applicant A __ __/__ __/__ __ __ __

Applicant B __ __/__ __/__ __ __ __

(d) Was this your first time in this type of Medicare plan?...	☐ Y ☐ N	☐ Y ☐ N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?..	☐ Y ☐ N	☐ Y ☐ N
(f) Did you drop a union group or employer health plan to enroll in this Medicare plan?..	☐ Y ☐ N	☐ Y ☐ N

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(g) Please indicate reason for termination/disenrollment:

	Check box(s) below if applicable: Applicant A	Applicant B
■ Your Medicare Advantage plan is leaving the Medicare program	☐	☐
■ Your Medicare Advantage organization stopped offering Medicare Advantage plans	☐	☐
■ Your Medicare Advantage organization stopped offering coverage in the area in which you live	☐	☐
■ You moved out of the geographic service area of your Medicare Advantage plan	☐	☐
■ You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan	☐	☐

■ Other: ______________________________
Applicant A

____
Applicant B

Please answer questions regarding other health insurance:

	Applicant A	Applicant B
4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)	☐ Y ☐ N	☐ Y ☐ N

If "YES," answer the following about this previous or existing coverage:

(a) What are your dates of coverage under the other policy/certificate?
If you are still covered under this plan, leave "END" blank............... Applicant A START __/__/____

END __/__/____

Applicant B START __/__/____

END __/__/____

(b) Planned date of termination/disenrollment?............ Applicant A __/__/____

Applicant B __/__/____

(c) With what company and what kind of policy/certificate? (List below.)

Applicant A	**Applicant B**
Name of Company	Name of Company
Policy/Certificate type	Policy/Certificate type

E. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:

	Applicant A	Applicant B
5. Are you applying during a guaranteed issue period? (NOTE: Refer to the guaranteed issue worksheet to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)	☐ Y ☐ N	☐ Y ☐ N
6. Did you turn age 65 in the last six months?	☐ Y ☐ N	☐ Y ☐ N
7. Did you enroll in Medicare Part B in the last six months?	☐ Y ☐ N	☐ Y ☐ N

If "YES," indicate your effective date......... Applicant A __/__/____

Applicant B __/__/____

STOP

IF EITHER YOU OR APPLICANT B ANSWERED "YES" TO QUESTION 5 OR BOTH QUESTIONS 6 AND 7 IN SECTION E, SKIP SECTIONS F & G AND GO TO SECTION H.

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If you are applying during an open enrollment or guaranteed issue period: SKIP SECTIONS F & G and GO TO SECTION H.

F. Health Information

For all plans, answer questions 8-18.

(If "YES" is answered to any of the following questions 8-16, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
8. Are you currently confined to a wheelchair or any motorized mobility device?	☐ Y ☐ N	☐ Y ☐ N
9. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility where you receive skilled nursing care, or receiving any occupational or physical therapy?	☐ Y ☐ N	☐ Y ☐ N
10. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing or any surgery that has not been performed?	☐ Y ☐ N	☐ Y ☐ N
11. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	☐ Y ☐ N	☐ Y ☐ N
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	☐ Y ☐ N	☐ Y ☐ N
C. Alzheimer's Disease, dementia or any other cognitive disorder?	☐ Y ☐ N	☐ Y ☐ N
D. Parkinson's Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?	☐ Y ☐ N	☐ Y ☐ N
E. Systemic Lupus or Myasthenia Gravis?	☐ Y ☐ N	☐ Y ☐ N
F. Acquired Immune Deficiency Syndrome (AIDS)?	☐ Y ☐ N	☐ Y ☐ N
G. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	☐ Y ☐ N	☐ Y ☐ N
H. Chronic hepatitis or cirrhosis?	☐ Y ☐ N	☐ Y ☐ N
I. Osteoporosis with fractures?	☐ Y ☐ N	☐ Y ☐ N
12. Do you have diabetes with complications including retinopathy, neuropathy, peripheral vascular disease, any related heart disorder (Including hypertension/high blood pressure) or kidney disease?	☐ Y ☐ N	☐ Y ☐ N
13. Do you have an implanted cardiac defibrillator?	☐ Y ☐ N	☐ Y ☐ N
14. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	☐ Y ☐ N	☐ Y ☐ N
B. Cardiomyopathy, Congestive Heart Failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?	☐ Y ☐ N	☐ Y ☐ N
C. Alcoholism or drug abuse?	☐ Y ☐ N	☐ Y ☐ N
D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	☐ Y ☐ N	☐ Y ☐ N
E. Internal cancer, lymphoma or melanoma?	☐ Y ☐ N	☐ Y ☐ N
F. A stroke or transient ischemic attack (TIA)?	☐ Y ☐ N	☐ Y ☐ N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?	☐ Y ☐ N	☐ Y ☐ N
15. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts?	☐ Y ☐ N	☐ Y ☐ N
16. Have you been hospital confined three or more times in the past two years for a same or similar condition?	☐ Y ☐ N	☐ Y ☐ N
17. Have you used tobacco in any form in the past 12 months?	☐ Y ☐ N	☐ Y ☐ N

18. Applicant A (Height) Ft ☐ In ☐☐ (Weight) Lbs ☐☐☐

Applicant B (Height) Ft ☐ In ☐☐ (Weight) Lbs ☐☐☐

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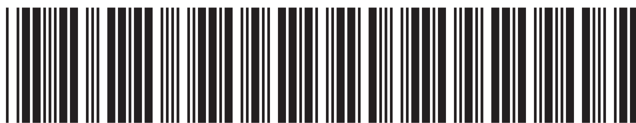

G. Medication Information

If you are applying OUTSIDE of an open enrollment or guaranteed issue period, please list all over-the-counter or prescription medications you have taken in the past 24 months in the table below.

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

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H. Agreement and Authorization

IMPORTANT STATEMENTS

- 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 coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the 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 reinstituted 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 reinstituted 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 reinstituted 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 reinstituted 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).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO GERBER LIFE INSURANCE COMPANY

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Gerber Life Insurance Company and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Gerber Life Insurance Company. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, Gerber Life Insurance Company, P.O. Box 2271, Omaha, NE 68103-2271. I realize that my right to revoke this authorization is limited to the extent that Gerber Life Insurance Company has taken action in reliance on the authorization or the law allows Gerber Life Insurance Company to contest the issuance of the policy or a claim under the policy.
- “Personal Information” means all health information, such as medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person’s medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant’s policy.

I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month’s premium has been received and/or processed and my application has been approved by Gerber Life Insurance Company.

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** and an Outline of Coverage.

✍ Dated at ______________________, on ____/____/________ ______________________________
City State Month Day Year Applicant A’s Signature

✍ Dated at ______________________, on ____/____/________ ______________________________
City State Month Day Year Applicant B’s Signature (if applying)

T03-2015-20

I. Producer Comments (please attach a separate sheet if needed)

J. To be Completed by Producer

19. Producers shall list any other health insurance policies/certificates they have sold to the applicant.

(a) List policies/certificates sold to the applicant which are still in force.

Applicant A
Applicant B

(b) List policies/certificates sold to the applicant in the past five (5) years which are no longer in force.

Applicant A
Applicant B

I/We certify as follows:

I/We have provided a copy of the replacement notice if the applicant is replacing coverage................................ ☐ Y ☐ N

I/We have accurately recorded in the application the information supplied by the applicant.............................. ☐ Y ☐ N

I/We certify that we have interviewed the proposed applicant... ☐ Y ☐ N

If you answered “NO” to any of the above statements, please explain why. ____

____

✍ ______________________________ Signature of Licensed Producer Date

______________________________ Printed Name

|_|_|_|_|_|_|_| Agent Writing Number

✍ ______________________________ Signature of Licensed Producer Date

______________________________ Printed Name

|_|_|_|_|_|_|_| Agent Writing Number

T03-2015-20

METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN

Part I. Select Premium Payment Option

	Applicant A	Applicant B
Initial Premium (Select option #1 or #2)		
✍ **Initial premium amount** (based on age at application date and includes one-time application fee in applicable states)....	$ ______.___	$ ______.___
1. Paper Check (submit signed check with application)...............	☐	☐
2. Automated Bank Account Withdrawal.....................................	☐	☐
Ongoing Premium Payments (Select option #1 or #2)		
1. I want my payments automatically withdrawn from my bank account every month on (**Circle** date).......................................	1st **or** 15th	1st **or** 15th
2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. **Select** frequency of billing)........	**every_____months** Insert 3, 6, or 12	**every_____months** Insert 3, 6, or 12

Part II. Payor Information

	Applicant A	Applicant B
Complete the following if premium is NOT paid by applicant (includes spouse or joint-married account):		
1. **Account Owner Name**, if different than applicant's.................	__________	__________
2. **Account Owner Relationship** to applicant:		
Living Trust	☐	☐
Power of Attorney or legal guardian (documentation required)	☐	☐
Business owned by applicant or applicant's spouse	☐	☐

Part III. Account Information

Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:
This section is intended as authorization to debit your bank account.
Complete bank account information below **OR** attach a copy of a voided check (Do NOT use a deposit slip)

Can attach voided check here

Applicant A
Account Type (check one): ☐ Checking ☐ Savings

____
Name of Financial Institution

____
Routing Number (9 digits on lower left side of check)

____
Account Number (Do NOT use Debit/Credit Card numbers)

____
Name as Shown on Account

Applicant B ☐ Same account as Applicant A
Account Type (check one): ☐ Checking ☐ Savings

____
Name of Financial Institution

____
Routing Number (9 digits on lower left side of check)

____
Account Number (Do NOT use Debit/Credit Card numbers)

____
Name as Shown on Account

- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Example:

Account Holder Name
Do NOT include the check # in the Routing or Account Number.
John Doe
Street Address
Town, City ZIP Code
Check #1234
Date:__________
Pay to:____________________
____________________Dollars
Routing/Transfer Number
Account Number
Financial Institution Name & Address
Memo__________ Signed By:__________
⑆123456789⑆ 12345678 ⑈ 1234 ⑈

IMPORTANT: When choosing to pay initial premium by Automated Bank Account Withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY. The first withdrawal date may be different from the monthly date selected for renewal premiums.
I authorize Gerber Life Insurance Company to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account to Gerber Life Insurance Company any preauthorized electronic fund transfers. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

✍ ____________________
Authorized Signature as Shown on Account

____
Date

✍ ____________________
Authorized Signature as Shown on Account

____
Date

T03_635

Gerber Life Insurance Company

Administrative Office
P.O. Box 2271
Omaha, Nebraska 68103-2271

Initial Premiums Paid through Automated Bank Account Withdrawal

Medicare supplement applications may have their initial premiums automatically deducted from their checking or savings account through a specific Electronic Funds Transfer (EFT) process identified as Automated Bank Account Withdrawal. When they do, you may fax the application and required forms instead of mailing them.

Follow these easy steps to submit Med supp apps using Automated Bank Account Withdrawal for initial premiums:

Step 1 - Complete the Method of Payment form

For applicants wishing to pay electronically for either their **initial** or **renewal** premium(s), complete the entire Med supp *Method of Payment* form (T03_635), included in the application package:

Step 2 - Fax the following items included in the application package to the dedicated line for Automated Bank Account Withdrawal payments at 1-866-422-9139

1. Automated Bank Account Withdrawal fax transmittal cover sheet on the back of this form, T03_627
2. Med supp *Method of Payment* form, T03_635
3. Med supp application and other required forms

Tips for Submitting Initial Premiums through Automated Bank Account Withdrawal

- Do not send a signed check for the initial premium; clients could be charged twice
- Do not fax the forms more than once; additional charges could result
- If you fax the forms, do not mail them, too; processing errors occur and additional charges result

For producer use only. Not for use with the general public.

T03_627

P.O. Box 2271
Omaha, NE 68103-2271

Call 1-877-617-5592
Fax 1-866-422-9139

Gerber Life Insurance Company

Fax

Use to Transmit Applications with Initial Payment by Automated Bank Account Withdrawal 1-866-422-9139*

*Use this fax number only for applications and new-business documents. Applications faxed to any other number can cause processing delays.

Please complete the following information:

Total number of pages being faxed (including this cover sheet)_____________

Producer Name	Producer Number or SSN
Phone Number	Fax Number

Comments ____

____

____

____

____

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This communication and any attachments transmitted with it are confidential and are solely for the use of the addressee. It may contain material that is legally privileged, proprietary or subject to copyright belonging to Gerber Life Insurance Company and its affiliates, and it may be subject to protection under federal or state law. If you are not the intended recipient, you are notified that any use of this material is strictly prohibited. If you received this transmission in error, please contact the sender immediately by telephone, collect calls accepted, at the number shown above. We will arrange for you to return the original material to us via the U.S. Postal Service, and if requested, we will reimburse you for such expense.

T03_627

Gerber Life
Insurance Company

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

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 Gerber Life Insurance Company. 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 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, Broker or Other Representative:

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 policy is being purchased for the following reason(s) (check one):

Applicant

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D

_____ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment

_____ Other (please specify)

____

____

____

Applicant B

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D

_____ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment

_____ Other (please specify)

____

____

____

If you still wish to terminate your present policy or certificate 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 premium 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 or certificate until you have received your new policy and are sure that you want to keep it.

______________________________ ______________________

Signature of Agent, Broker or Other Representative **Date**

Gerber Life Insurance Company, P.O. Box 2271, Omaha, Nebraska 68103-2271

Applicant	**Applicant B**
Signature ✍	Signature ✍
Date	Date

T03_202

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and client notifications on the following pages are to be given to the applicant(s) if applicable.

Replacement Notice

If replacing, both you and the applicant must sign the customer copy of the replacement notice.

Premium Receipt / Notice of Information Practices

Gerber Life
Insurance Company

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

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 Gerber Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

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Statement to Applicant by Issuer, Agent, Broker or Other Representative:

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 policy is being purchased for the following reason(s) (check one):

Applicant

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D

_____ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment

_____ Other (please specify)

____

____

____

Applicant B

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D

_____ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment

_____ Other (please specify)

____

____

____

If you still wish to terminate your present policy or certificate 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 premium 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 or certificate until you have received your new policy and are sure that you want to keep it.

______________________________ ______________

Signature of Agent, Broker or Other Representative **Date**

Gerber Life Insurance Company, P.O. Box 2271, Omaha, Nebraska 68103-2271

Applicant	**Applicant B**
Signature ✍	Signature ✍
Date	Date

T03_202

Gerber Life
Insurance Company

Premium Receipt

All premiums must be made payable to Gerber Life Insurance Company.

Do not make check payable to the agent or leave the payee blank.

Applicant A

Received from ____________________

this _____ day of ____________________ , __________

an application for Form____________________Policy

and/or Riders ____________________and

Check for ____________________Dollars.

Agent ____________________

Applicant B

Received from ____________________

this _____ day of ____________________ , __________

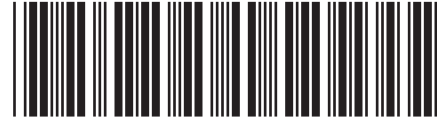
an application for Form____________________Policy

and/or Riders ____________________and

Check for ____________________Dollars.

Agent ____________________

No insurance of any kind shall take effect until a policy is issued and delivered to the applicant, and the initial premium is paid, all during the life of the applicant. If no policy is issued, Gerber Life Insurance Company shall have no liability except to refund the initial premium to the applicant. This is a receipt of your application and initial premium.



Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: GERBER LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, P.O. BOX 2271, OMAHA, NE 68103-2271.

T03_364

Provide the completed premium receipt, if applicable, and notice to the applicant.