An Absolute Broker

FAX/MAIL COVER LETTER

**Please FAX or MAIL this cover letter with the completed application to:

An Absolute Broker (mailing address below)

FAX# 775.522.7777

Dear An Absolute Broker,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

☐ Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

☐ I will contact An Absolute Broker at 910.232.4964 to verify receipt of my application.

**I understand that An Absolute Broker will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend

I understand that the original, signed application and premium payment must still be mailed to An Absolute Broker. :

An Absolute Broker
Attn: New Enrollment
1319 Millitary Cutoff Rd #188
Wilmington, NC 28405

I will send the original, signed application and premium payment, as soon as I have been contacted by An Absolute Broker with confirmation that my application has been received by fax and reviewed for completeness.

Genworth® Financial

American Continental Insurance Company
A Genworth Financial Company
101 Continental Place
Brentwood, TN 37027

Health Information Authorization

from American Continental Insurance Company

- Print clearly and use blue or black ink.
- This is a HIPAA Compliant Authorization.

To Agent: Have applicant complete and sign home office copy to submit with application. Applicant keeps one copy.

Applicant declarations

Please read these statements carefully

I authorize the use and disclosure of health information about me as described herein.

Health Information to be Used or Disclosed: This Authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive; the past, present, or future payment for my health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; alcoholism and mental illness; and may be in electronic or paper form. It does not include information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: American Continental Insurance Company; its insurance support organizations; its affiliates and reinsurers.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: physicians; health professionals; hospitals; clinics; the Veterans Administration; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; consumer reporting agencies; insurance support organizations.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my application; determine premium amounts, adjudicate claims and to support the operations of our health plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization; and that a copy of it is as valid as the original; (2) this Authorization will be valid for 24 months from the date signed; (3) if I do not sign this Authorization, or revoke it by writing to American Continental Insurance Company at its Administrative Office, the Company may decline my application; and (4) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization (5) Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Primary applicant please fill in this information

Signature of applicant	Date
X	.
Printed name of applicant	
X	
City	State / Zip
.	. / .

Other important information

Producer Compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

Genworth®
Financial

101 Continental Place
Brentwood, Tennessee 37027
800 264.4000
cont-life.com

APPLICATION

MEDICARE SUPPLEMENT INSURANCE

Underwritten by
American Continental Insurance Company

South Carolina

ACIMS0333SC 030310

Genworth® Financial

American Continental Insurance Company
A Genworth Financial Company
101 Continental Place
Brentwood, TN 37027

Application for Medicare Supplement Insurance
from American Continental Insurance Company

- Print clearly and use blue or black ink.

1. Proposed insured information

Write the name as stated on the Medicare card. Provide a copy of the Medicare card with the application if possible.

Full name of proposed insured *First, M.I., Last*

Address

Phone

City

State

Zip

E-mail

Social Security Number

Write the date of birth that is on the birth certificate.

Birth date *mm/dd/yyyy*

Age

Height *Feet and inches*

Weight *Pounds*

○ Male ○ Female

Are you a legal resident of the United States? ○ Yes ○ No

Have you used any form of tobacco in the past 12 months? ○ Yes ○ No

Include any letters associated with the Medicare number and in the appropriate position. If applicant has not received a Medicare card yet, put "No Medicare number yet".

Medicare card number

Date enrolled in: Medicare Part A

Medicare Part B

For Agent Use Only:

Check one if application is for: ○ Open Enrollment ○ Guaranteed Issue

2. Plan and premium information

Plan selected:

Requested Medicare Supplement effective date *mm/dd/yyyy*

You have a choice among several payment options or modes for paying your premium (annual, semi-annual, quarterly and monthly electronic funds transfer).

Annual premium:
$

Payment mode
○ Annually ○ Quarterly
○ Semi-Annually ○ Monthly EFT (Electronic Funds Transfer)

Modal premium:
$

Policy fee:
$

Total modal premium collected/draft:
$

PAYMENT MODES

Each payment mode, other than annual and monthly electronic funds transfer, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates. The annual and monthly electronic funds transfer modes have the same and lowest total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You may change your payment mode, among the modes available, during the life of your policy.

3. Eligibility questions

Please answer all questions.

To the best of your knowledge:

1. Did you turn age 65 in the last 6 months? ○ Y ○ N
   A. Did you enroll in Medicare Part B in the last 6 months? ○ Y ○ N
   B. If yes, what is the effective date?
   . / /

NOTE: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to question 2.

2. Are you covered for medical assistance through the state Medicaid program? ○ Y ○ N
   A. If yes: Will Medicaid pay your premiums for this Medicare Supplement policy? ○ Y ○ N
   B. Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium? ○ Y ○ N

3. If 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), fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.
   Start date . / / End date . / /
   A. 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
   B. Was this your first time in this type of Medicare plan? ○ Y ○ N
   C. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ○ Y ○ N

4. Do you have another Medicare Supplement policy inforce? ○ Y ○ N
   A. If so, with what company, and what plan do you have?
   Company . Plan .
   B. If so, do you intend to replace your current Medicare Supplement policy with this policy? ○ Y ○ N

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.

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ○ Y ○ N
   A. If so, with what company, and what kind of policy?
   Company . Plan .
   B. What are your start and end dates of coverage under the other policy? (If you are still covered under the other policy, leave "End" blank.)
   Start date . / / End date . / /

4. Health questions

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

If the health questions are answered for an Open Enrollment or Guaranteed Issue application, the application cannot be processed and will be returned.

If any health questions are answered "yes" in Section 4, the applicant does not qualify for this insurance with us.

1. Are you dependent on a wheelchair or any motorized mobility device?	○ Y	○ N
2. Do any of the following apply to you?		
Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy	○ Y	○ N
3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. congestive heart failure, unoperated aneurysm, defibrillator	○ Y	○ N
B. leukemia, lymphoma, multiple myeloma, cirrhosis	○ Y	○ N
C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy	○ Y	○ N
D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease	○ Y	○ N
E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	○ Y	○ N
F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV)	○ Y	○ N
4. Do you have diabetes?		
A. that requires use of insulin	○ Y	○ N
B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage	○ Y	○ N
C. with history of heart attack or stroke (at any time)	○ Y	○ N
D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	○ Y	○ N
5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. alcoholism, drug abuse	○ Y	○ N
B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder	○ Y	○ N
C. internal cancer, melanoma, Hodgkin's Disease	○ Y	○ N
D. hepatitis, disorder of the pancreas	○ Y	○ N
6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease	○ Y	○ N
B. myasthenia gravis, systemic lupus or connective tissue disorder	○ Y	○ N
C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	○ Y	○ N
D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder	○ Y	○ N
E. any lung or respiratory disorder and currently use tobacco products	○ Y	○ N
7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or any surgery that has not been performed?	○ Y	○ N
8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?	○ Y	○ N

9. Within the past 12 months, do any of the following apply to you?		
A. had a pacemaker implanted	○ Y	○ N
B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer	○ Y	○ N
C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer	○ Y	○ N
D. had a seizure	○ Y	○ N
10. Was your last blood pressure reading higher than 175 Systolic or higher than 100 Diastolic?	○ Y	○ N

Systolic is the upper number and Diastolic is the bottom number of a blood pressure reading.

5. Health history

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

2. Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

3. **Prescribed medications**	**Reason for medications (diagnosis)**

Use an additional sheet of paper if needed for explanation.

6. Physician information

Your primary physician Phone

Physician's office name

City State

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Have you seen any additional physicians other than those listed above in the past 24 months? ○ Y ○ N

7. Important statements

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. 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 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.
5. 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 suspension.
6. 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).

8. Privacy notice

Although your application is our initial source of information, we may collect information, including health history and medical records, from persons other than you and we may conduct a telephone interview with you. American Continental Insurance Company, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

9. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

10. Applicant agreement

I hereby apply to American Continental Insurance Company for a policy to be issued in reliance on my written answers to the questions on this application. I have read and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are true, complete and correctly recorded. I acknowledge that I have received an outline of coverage for the policy applied for and *A Guide to Health Insurance for People with Medicare*.

I agree (1) this application and any policy issued will constitute the entire contract of insurance and the Company will not be bound in any way by any statements, promises or information made or given by or to any agent or other person at any time unless the same is in writing and submitted to the Company at its Home Office and made a part of such contract. Only a Company Officer can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing; and (2) the policy shall not be effective until it has actually been issued by the Company and said policy is manually received and accepted by me and the first premium paid, and there has been no change in my health as stated in the application.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand that if any answers on this application are incorrect, incomplete or untrue, American Continental Insurance Company has the right to adjust my premium, reduce my benefits or rescind this policy subject to the Time Limit on Certain Defenses.

Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicant signature	Date signed
X	.

11. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Proposed insured's name

▪

Account owner name, if different than proposed insured's

▪

Account owner relationship to proposed insured:

◯ Business owned by proposed insured ◯ Living trust ◯ Employer
◯ Power of Attorney ◯ Conservator/guardian
◯ Family member; specify ▪

Financial institution name

▪

◯ Checking ◯ Savings

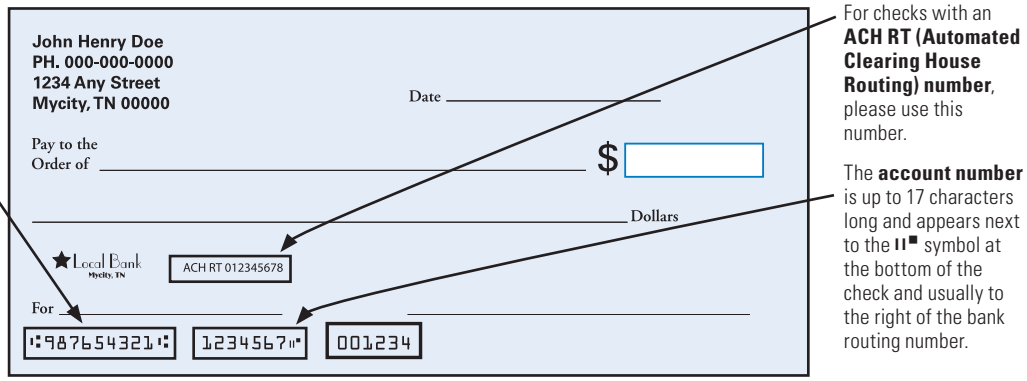
Routing number

▪

Account number

▪

This is an example of a personal check. A business check may be different.



For all other checks, use the nine-character bank **routing number**, which appears between the ⑆ symbols, usually at the bottom left corner of the check.

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the ⑈ symbol at the bottom of the check and usually to the right of the bank routing number.

12. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner

X ▪

Date

▪

13. Agent

All information **must** be completed.

Please list any other medical or health insurance policies sold to the proposed insured.

1) List policies sold which are still in force

.

.

2) List policies sold in the past 5 years which are no longer in force

.

.

I certify that:

1. I have accurately recorded the information supplied by the applicant.
2. The application was provided to the applicant to review and the applicant has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy.
3. I have provided an outline of coverage for the policy applied for and *A Guide to Health Insurance for People with Medicare* to applicant prior to completing the application.

The writing number reflects where commissions will be paid.

Agent name *Printed*	Writing number (agent or company)
. Mark Sheffield	. GNW0022751
Agent signature	State license ID number (for FL only)
X	.
Phone	E-mail
. 910-232-4964	. mrkshef@yahoo.com

14. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through American Continental Insurance Company (ACI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACI commission schedule.

Agent Information *Print*

Writing Agent		Percentage
. Mark Sheffield		. 100 %
Secondary Agent	Writing number	Percentage
.	.	. %

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing Agent Signature

X

American Continental Insurance Company
A Genworth Financial Company
101 Continental Place
Brentwood, TN 37027

800 264.4000
cont-life.com
office hours 7:30 a.m. - 4:30 p.m. CST

Receipt
from American Continental Insurance Company

- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.

Proposed insured's name *Printed*
.

Date of application
.

Initial payment collected (if applicable)
$

○ Check ○ Money order

EFT draft amount
$

This acknowledges receipt of your application for an American Continental Insurance Company Medicare Supplement insurance policy.

Agent name *Printed*
. Mark Sheffield

Phone
. 910-232-4964

Signature of agent
X

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to American Continental Insurance Company.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

Medicare Supplement Insurance - A. If this payment equals the full, initial premium for the mode of premium payment selected by the applicant; and B. if the answers are true and correct in the application and if American Continental Insurance Company issues a Medicare Supplement policy according to its rules, limits, and standards for the plan and amount applied for by the applicant; then this payment shall be applied to the payment of the first premium of the issued Medicare Supplement policy. No Medicare Supplement policy shall be effective until it has actually been issued by American Continental Insurance Company.

Thank you for choosing American Continental Insurance Company!

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

American Continental Insurance Company
101 Continental Place, Brentwood, Tennessee 37027

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

According to (your application) (information you have furnished), you intend to terminate existing Medicare Supplement or Medicare Advantage and replace it with a policy to be issued by American Continental 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 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 PRODUCER: 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):

_____ 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) _____
_____

(1) 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 under the original policy.

(3) 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 or certificate 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.

(4) Do not cancel your present policy or certificate until you have received your new policy or certificate and are sure that you want to keep it.

_____ _____
Signature of Agent Signature of Applicant
Mark Sheffield Date: _____
_____
Printed Name of Agent
1319 CC Military Cutoff Rd. #188, Wilmington, NC 28405
_____
Address of Agent
Date: _____

WHITE COPY: Home Office with Completed Application – YELLOW COPY: Applicant

AC00003

Genworth®
Financial

101 Continental Place
Brentwood, Tennessee 37027
800 264.4000
cont-life.com

OUTLINE OF COVERAGE

MEDICARE SUPPLEMENT INSURANCE

BENEFIT PLANS

Underwritten by
American Continental Insurance Company

South Carolina

AMERICAN CONTINENTAL INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N

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, co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments
Blood: First three pints of blood each year. Hospice-Part A coinsurance

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	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 coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $[4140]; paid at 100% after limit reached	Out-of-pocket limit $[2000]; paid at 100% after limit reached		

*Plans 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 [$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Annual Attained Age Premiums

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan A

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
65	1,049	1,207	1,166	1,341
66	1,049	1,207	1,166	1,341
67	1,049	1,207	1,166	1,341
68	1,094	1,257	1,215	1,397
69	1,142	1,314	1,269	1,459
70	1,188	1,366	1,319	1,518
71	1,234	1,419	1,370	1,576
72	1,276	1,468	1,418	1,630
73	1,316	1,514	1,462	1,682
74	1,355	1,557	1,505	1,730
75	1,389	1,597	1,542	1,774
76	1,421	1,633	1,578	1,815
77	1,451	1,667	1,613	1,854
78	1,478	1,701	1,644	1,889
79	1,505	1,730	1,672	1,922
80	1,530	1,759	1,699	1,953
81	1,551	1,783	1,723	1,981
82	1,571	1,807	1,746	2,008
83	1,593	1,831	1,769	2,035
84	1,612	1,853	1,791	2,059
85	1,630	1,875	1,811	2,084
86	1,649	1,896	1,832	2,107
87	1,666	1,916	1,852	2,128
88	1,683	1,936	1,870	2,151
89	1,699	1,953	1,888	2,171
90	1,714	1,972	1,905	2,189
91	1,728	1,988	1,920	2,209
92	1,741	2,002	1,935	2,226
93	1,753	2,017	1,948	2,241
94	1,766	2,029	1,961	2,255
95	1,775	2,041	1,973	2,268
96	1,786	2,054	1,983	2,282
97	1,796	2,065	1,996	2,295
98	1,806	2,078	2,007	2,309
99	1,818	2,090	2,020	2,322

Medicare Supplement Policy
2010 Standardized Plan B

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
65	1,323	1,520	1,470	1,689
66	1,323	1,520	1,470	1,689
67	1,323	1,520	1,470	1,689
68	1,377	1,585	1,531	1,760
69	1,440	1,656	1,599	1,839
70	1,498	1,721	1,663	1,913
71	1,554	1,787	1,727	1,985
72	1,608	1,849	1,787	2,055
73	1,659	1,907	1,843	2,119
74	1,707	1,963	1,896	2,180
75	1,750	2,011	1,944	2,235
76	1,790	2,058	1,989	2,286
77	1,827	2,102	2,031	2,337
78	1,863	2,143	2,070	2,380
79	1,896	2,180	2,107	2,423
80	1,926	2,215	2,141	2,461
81	1,953	2,247	2,171	2,497
82	1,980	2,278	2,201	2,530
83	2,006	2,308	2,229	2,563
84	2,030	2,334	2,257	2,594
85	2,055	2,362	2,283	2,625
86	2,078	2,389	2,309	2,656
87	2,100	2,415	2,332	2,682
88	2,121	2,439	2,356	2,709
89	2,141	2,463	2,378	2,735
90	2,159	2,484	2,400	2,759
91	2,178	2,504	2,419	2,783
92	2,195	2,523	2,438	2,804
93	2,210	2,542	2,455	2,823
94	2,224	2,558	2,471	2,841
95	2,236	2,572	2,486	2,859
96	2,250	2,587	2,500	2,875
97	2,263	2,602	2,515	2,892
98	2,276	2,617	2,529	2,909
99	2,290	2,633	2,545	2,926

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833

The rates above do not include a one time $20 policy fee.

Area Factors:

South Carolina

294, 295, 299	0.90
Rest of State	0.85

Annual Attained Age Premiums

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan F

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
65	1,536	1,767	1,707	1,963
66	1,536	1,767	1,707	1,963
67	1,536	1,767	1,707	1,963
68	1,600	1,839	1,777	2,044
69	1,662	1,912	1,848	2,124
70	1,723	1,982	1,915	2,202
71	1,783	2,051	1,981	2,279
72	1,839	2,116	2,043	2,350
73	1,889	2,172	2,099	2,413
74	1,937	2,229	2,153	2,475
75	1,981	2,279	2,202	2,532
76	2,020	2,322	2,243	2,580
77	2,055	2,362	2,283	2,625
78	2,086	2,400	2,318	2,665
79	2,116	2,434	2,350	2,703
80	2,142	2,464	2,380	2,737
81	2,170	2,496	2,411	2,774
82	2,198	2,528	2,442	2,808
83	2,224	2,558	2,471	2,843
84	2,250	2,587	2,500	2,875
85	2,275	2,616	2,528	2,907
86	2,298	2,643	2,554	2,937
87	2,322	2,670	2,579	2,965
88	2,343	2,694	2,603	2,993
89	2,362	2,718	2,625	3,020
90	2,383	2,739	2,646	3,044
91	2,401	2,759	2,666	3,067
92	2,416	2,778	2,686	3,087
93	2,432	2,796	2,702	3,106
94	2,444	2,812	2,717	3,124
95	2,457	2,826	2,730	3,139
96	2,470	2,840	2,744	3,156
97	2,483	2,854	2,758	3,171
98	2,496	2,869	2,773	3,188
99	2,507	2,884	2,787	3,204

Medicare Supplement Policy
2010 Standardized Plan High F

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
65	604	695	671	772
66	604	695	671	772
67	604	695	671	772
68	629	723	699	804
69	654	752	727	835
70	678	780	753	866
71	701	807	779	896
72	723	832	804	924
73	743	854	826	949
74	762	877	847	974
75	779	896	866	996
76	795	913	882	1,015
77	808	929	898	1,033
78	821	944	912	1,048
79	832	957	924	1,063
80	843	969	936	1,077
81	854	982	948	1,091
82	865	994	961	1,105
83	875	1,006	972	1,118
84	885	1,018	983	1,131
85	895	1,029	994	1,143
86	904	1,040	1,005	1,155
87	913	1,050	1,014	1,166
88	922	1,060	1,024	1,177
89	929	1,069	1,033	1,188
90	937	1,077	1,041	1,197
91	944	1,085	1,049	1,206
92	950	1,093	1,057	1,214
93	957	1,100	1,063	1,222
94	961	1,106	1,069	1,229
95	966	1,112	1,074	1,235
96	972	1,117	1,079	1,241
97	977	1,123	1,085	1,247
98	982	1,129	1,091	1,254
99	986	1,134	1,096	1,260

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833

The rates above do not include a one time $20 policy fee.

Area Factors:

South Carolina

294, 295, 299	0.90
Rest of State	0.85

Annual Attained Age Premiums

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan G

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
65	1,345	1,546	1,494	1,718
66	1,345	1,546	1,494	1,718
67	1,345	1,546	1,494	1,718
68	1,401	1,611	1,557	1,790
69	1,464	1,684	1,627	1,871
70	1,522	1,751	1,691	1,945
71	1,580	1,817	1,756	2,019
72	1,635	1,880	1,817	2,089
73	1,687	1,940	1,874	2,155
74	1,735	1,996	1,928	2,217
75	1,779	2,046	1,977	2,273
76	1,820	2,093	2,022	2,325
77	1,859	2,138	2,066	2,375
78	1,895	2,179	2,106	2,421
79	1,928	2,217	2,142	2,463
80	1,959	2,253	2,177	2,503
81	1,987	2,286	2,208	2,540
82	2,014	2,316	2,238	2,574
83	2,040	2,346	2,267	2,607
84	2,065	2,375	2,295	2,639
85	2,090	2,403	2,322	2,670
86	2,113	2,430	2,348	2,700
87	2,135	2,456	2,373	2,729
88	2,157	2,480	2,397	2,756
89	2,177	2,504	2,419	2,782
90	2,196	2,526	2,441	2,807
91	2,215	2,547	2,461	2,830
92	2,231	2,566	2,479	2,851
93	2,247	2,584	2,497	2,871
94	2,262	2,601	2,513	2,890
95	2,275	2,616	2,527	2,907
96	2,288	2,631	2,542	2,924
97	2,302	2,647	2,557	2,941
98	2,315	2,662	2,572	2,958
99	2,329	2,678	2,588	2,976

Medicare Supplement Policy
2010 Standardized Plan N

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
65	1,068	1,228	1,187	1,365
66	1,068	1,228	1,187	1,365
67	1,068	1,228	1,187	1,365
68	1,113	1,280	1,237	1,422
69	1,163	1,338	1,293	1,486
70	1,209	1,391	1,344	1,546
71	1,255	1,443	1,394	1,604
72	1,299	1,494	1,443	1,660
73	1,340	1,541	1,489	1,712
74	1,378	1,585	1,532	1,762
75	1,414	1,625	1,570	1,806
76	1,446	1,662	1,606	1,848
77	1,478	1,698	1,642	1,886
78	1,506	1,732	1,673	1,924
79	1,531	1,762	1,701	1,956
80	1,557	1,790	1,730	1,989
81	1,579	1,815	1,755	2,017
82	1,600	1,839	1,778	2,044
83	1,621	1,863	1,801	2,071
84	1,642	1,886	1,823	2,097
85	1,660	1,909	1,844	2,120
86	1,678	1,930	1,865	2,144
87	1,696	1,950	1,885	2,167
88	1,714	1,971	1,903	2,190
89	1,730	1,990	1,922	2,210
90	1,745	2,006	1,939	2,230
91	1,759	2,023	1,954	2,249
92	1,772	2,038	1,970	2,266
93	1,785	2,053	1,983	2,281
94	1,796	2,066	1,997	2,295
95	1,807	2,078	2,009	2,308
96	1,818	2,090	2,019	2,322
97	1,828	2,103	2,031	2,336
98	1,838	2,115	2,043	2,350
99	1,850	2,128	2,056	2,364

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833

The rates above do not include a one time $20 policy fee.

Area Factors:

South Carolina

294, 295, 299	0.90
Rest of State	0.85

PREMIUM INFORMATION

American Continental Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the policy will be the renewal premium then in effect for your attained age. Other policies may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age policies.

Premiums payable other than annual will be determined according to the following factors:

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

DISCLOSURES

Use this outline to compare benefits and premium among policies. This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J will no longer be available for sale after May 31, 2010.

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 American Continental Insurance Company, P.O. Box 2368, Brentwood, Tennessee 37024. 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 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 cover all of your medical costs.

Neither American Continental Insurance Company 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 any 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.

THE FOLLOWING CHARTS DESCRIBE PLANS A, B, F, HIGH DEDUCTIBLE F, G and N OFFERED BY AMERICAN CONTINENTAL INSURANCE COMPANY.

PLAN A

MEDICARE (PART A) – MEDICAL SERVICES – PER CALENDAR YEAR

*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 PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1100]	$0	[$1100] (Part A Deductible)
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$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
21st thru 100th day	All but [$137.50] a day	$0	Up to[$137.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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

**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'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.

PLAN A

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

*Once you have been billed [$155] 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 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 test, durable medical equipment			
First [$155] of Medicare-Approved amounts*	$0	$0	[$155] (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare-Approved amounts*	$0	$0	[$155] (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$155]of Medicare Approved amounts*	$0	$0	[$155] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN B

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 PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1100]	[$1100] (Part A Deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$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
21st thru 100th day	All but [$137.50] a day	$0	Up to [$137.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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

**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 365 days as provided in the policy'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.

PLAN B

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

* Once you have been billed [$155] 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 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 test, durable medical equipment			
First [$155] of Medicare-Approved amounts*	$0	$0	[$155] (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare-Approved amounts*	$0	$0	[$155] (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$155] of Medicare Approved amounts*	$0	$0	[$155] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

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 PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1100]	[$1100] (Part A Deductible)	$0
61st thru 90th day	All but $275 a day	[$275] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$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
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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

**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 365 days as provided in the policy'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.

PLAN F

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

*Once you have been billed [$155] 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 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 test, durable medical equipment			
First [$155] of Medicare-Approved amounts*	$0	[$155] (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare-Approved amounts*	$0	[$155] (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$155] of Medicare Approved amounts*	$0	[$155] (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN 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
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

High Deductible F

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.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2000] DEDUCTIBLE** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1100]	[$1100] (Part A Deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$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
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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

**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 365 days as provided in the policy'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.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed [$155] 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.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2000] DEDUCTIBLE** 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 test, durable medical equipment			
First [$155] of Medicare-Approved amounts*	$0	[$155] (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare-Approved amounts*	$0	[$155] (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2000] DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$155] of Medicare Approved amounts*	$0	[$155] (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2000] DEDUCTIBLE** 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
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN 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 PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1100]	[$1100] (Part A Deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$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
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	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 365 days as provided in the policy'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.

PLAN G

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

*Once you have been billed [$155] 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 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 test, durable medical equipment			
First [$155] of Medicare-Approved amounts*	$0	$0	[$155] (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare-Approved amounts*	$0	$0	[$155] (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$155] of Medicare Approved amounts*	$0	$0	[$155] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN 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
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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 PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1100]	[$1100] (Part A Deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$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
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ 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 365 days as provided in the policy'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.

PLAN N

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

*Once you have been billed [$155] 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 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 test, durable medical equipment			
First [$155] of Medicare-Approved amounts*	$0	$0	[$155] (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare-Approved amounts*	$0	$0	[$155] (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$155] of Medicare Approved amounts*	$0	$0	[$155] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN 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
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum