

# 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 Military 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.

# An Absolute Broker

## Application Instructions for Great American

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to An Absolute Broker for review along with the completed application. If you do not have access to a fax machine, send the completed application to An Absolute Broker along with the required first month's payment.

## HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

## IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Great American** if you are not paying by credit card for the first month.

Mail completed applications and check to:

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

An Absolute Broker will review your application for completeness and accuracy before we submit it to Great American for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 910.232.4964 or e-mail us at [mrkshef@yahoo.com](mailto:mrkshef@yahoo.com).

Norvax form #IN-1

# MEDICARE SUPPLEMENT

## Insurance Application



### Supplemental Benefits Group

**Our Companies include:**

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



PV Case #: \_\_\_\_\_

**APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE**

(Please select Company below)

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

OE    GI    Underwritten    Disabled (underage)    New Business    Reinstatement    Benefit Change  
Requested Medicare Supplement Effective Date: \_\_\_\_\_

**SECTION I – APPLICANT INFORMATION (PRINT)**

Name of Applicant			Date of Birth		
Last	First	Middle Initial	Month	Day	Year
Age	Social Security No.		Gender		
	-	-	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Resident Street Address (No P. O. Box)			City	State	Zip
Mailing Address (if different from above)			City	State	Zip
Telephone Number (   )   -			E-mail Address		
Medicare Card No.			Height		Weight
-			Ft   In		Lbs

Have you used tobacco within the last 12 months?    YES    NO

Rate Class:    Preferred    Standard

**SECTION II - COVERAGE APPLIED FOR**

Check plan selected (plan availability varies by company):

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

**SECTION III - PREMIUM PAYMENT INFORMATION**

Draft bank account for 1<sup>st</sup> premium\*    Check enclosed for 1<sup>st</sup> premium\*

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

Select payment method:

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

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

Amount Enclosed: \$ \_\_\_\_\_

**MAKE CHECKS PAYABLE TO THE INSURANCE COMPANY.**

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

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

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

**SECTION V – MEDICARE**

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

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

**SECTION VI - MEDICAL QUESTIONS**

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

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

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

Medication	Dates Taken	Condition Taken For

NOTE: Please attach a separate sheet if needed.

**SECTION VII - COMMENTS**

**SECTION VIII – IMPORTANT STATEMENTS FOR APPLICANT TO READ**

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

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

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

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

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

Telephone Number: (        ) \_\_\_\_\_

Best Time to Call: \_\_\_\_\_

\_\_\_\_\_  
Applicant's Printed Name

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**SECTION IX - AGENT'S CERTIFICATION**

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

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

\_\_\_\_\_

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

\_\_\_\_\_

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

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

(a) Application Packet (Phone Sale Only)

(c) Outline of Medicare Supplement Coverage

(b) *A Guide to Health Insurance for People with Medicare*

(d) Other: \_\_\_\_\_

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

In Person \_\_\_\_\_  
(Date)

By Mail \_\_\_\_\_  
(Date)

Email \_\_\_\_\_  
(Date)

Fax: \_\_\_\_\_  
(Date)

Other (Explain): \_\_\_\_\_  
(Date)

**YES NO**

5. Was the Application completed by you in the Applicant's physical presence? .....

6. Was the Application completed by you over the phone?.....

7. Do you have knowledge or reason to believe the replacement of existing insurance may be involved? .

If "YES" give Name of Company, reason and termination date \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Mark Sheffield  
Printed Name of 1<sup>st</sup> Licensed Agent

\_\_\_\_\_  
Signature of 1<sup>st</sup> Licensed Agent

HM05662  
Writing Number

100%  
Percentage

\_\_\_\_\_  
Printed Name of 2<sup>nd</sup> Licensed Agent

\_\_\_\_\_  
Signature of 2<sup>nd</sup> Licensed Agent

\_\_\_\_\_  
Writing Number

\_\_\_\_\_  
Percentage



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

(must select one below):

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

Proposed Insured's Name \_\_\_\_\_ Policy Number (if Available) \_\_\_\_\_

Financial Institution Name and Telephone Number \_\_\_\_\_

Financial Institution Address \_\_\_\_\_

9 Digit Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

**Requested Withdrawal Date (1st thru 28th):** \_\_\_\_\_

**Withdraw Payment:**     Monthly     Quarterly     Semi-Annually     Annually

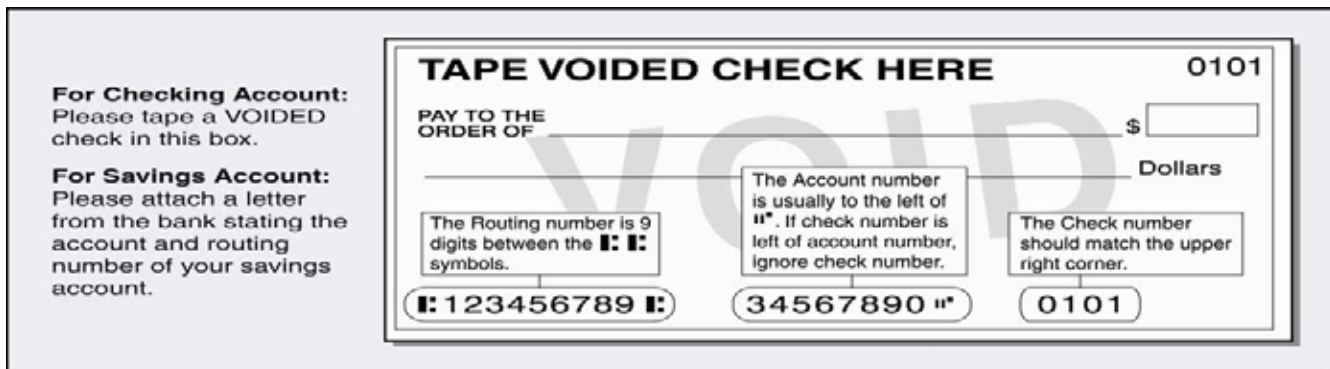
**Type of Account:**

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

Name of Employer Group \_\_\_\_\_

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

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



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

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

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

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

**GREAT AMERICAN SUPPLEMENTAL BENEFITS GROUP OFFICIAL RECEIPT**  
**UNLESS EFT/ACH FORM IS USED A CHECK OR MONEY ORDER MUST ACCOMPANY APPLICATION**

(Please select Company below)

Loyal American Life Insurance Company®

Received of \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ (M) / \_\_\_\_\_ (Y), an application for a Form \_\_\_\_\_ Policy and

Check or Money order for \_\_\_\_\_ Dollars.

Should the Company decline to issue the insurance applied for, the Company hereby agrees to return the above sum to the applicant.

\_\_\_\_\_ Agent

If the full premium is paid with the application and so recorded in the application and the Company shall be satisfied after investigation that the applicant was acceptable for the insurance applied for at the time the application was signed according to the underwriting rules of the Company the policy will be dated and effective according to its terms at 12:01 A.M. the day the application was dated or the date on which the premium was paid, whichever is later. ALL PREMIUM CHECKS OR ANNUITY CONSIDERATIONS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY – DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.



Supplemental Benefits Group

01/10

**GASBG-9-0044**



**Our Companies include:**

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

P. O. Box 559015 | Austin, TX 78755-9015



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

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

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

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

\_\_\_\_\_

\_\_\_\_\_  
Applicant's Name

\_\_\_\_\_  
Name of applicant's personal representative, if applicable

\_\_\_\_\_  
Applicant's Social Security Number

\_\_\_\_\_  
Relationship of personal representative to the applicant

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Company's Agent

\_\_\_\_\_  
Date

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

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

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

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

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

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

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by the Company selected above. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY ISSUER, AGENT OR BROKER:**

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

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

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

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

\_\_\_\_\_  
Agent's Signature Mark Sheffield  
1319 Military Cutoff Rd #188, Wilmington,  
Type or Print Name and Address of Agent or Broker

\_\_\_\_\_  
Applicant's Signature  
\_\_\_\_\_  
Date

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

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

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

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

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

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by the Company selected above. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY ISSUER, AGENT OR BROKER:**

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

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

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

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

\_\_\_\_\_  
Agent's Signature Mark Sheffield  
1319 Military Cutoff Rd #188, Wilmington,  
Type or Print Name and Address of Agent or Broker

\_\_\_\_\_  
Applicant's Signature  
\_\_\_\_\_  
Date