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.

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 Millitary 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.

Norvax form #IN-1

MEDICARE SUPPLEMENT

Insurance Application

GREAT AMERICAN.
FINANCIAL RESOURCES

Supplemental Benefits Group

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

PV Case #: _____

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

(Please select Company below)

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

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

Requested Medicare Supplement Effective Date: _____

SECTION I – APPLICANT INFORMATION (PRINT)

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

Age	**Social Security No.** - -	**Gender** ☐ Male ☐ 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** Ft In	**Weight** Lbs	

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

Do you have any other coverage in force that includes, but not limited to, health, cancer, accident and/or hospital indemnity? ☐ **YES** ☐ **NO**

Rate Class: ☐ Preferred ☐ Standard

SECTION II - COVERAGE APPLIED FOR

Check plan selected (plan availability varies by company):

☐ Plan A ☐ Plan D ☐ Plan N

☐ Plan B ☐ Plan F

☐ Plan C ☐ Plan G

SECTION III - PREMIUM PAYMENT INFORMATION

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

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

Select payment method:

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

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

Amount Enclosed: $_____

MAKE CHECKS PAYABLE TO THE INSURANCE COMPANY.

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

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

To the best of your knowledge,	YES	NO
1. (a) Did you turn age 65 in the last 6 months?	☐	☐
(b) Did you enroll in Medicare Part B in the last 6 months?	☐	☐
If "YES", what is the effective date? _____.		
2. Are you covered for medical assistance through the state Medicaid program? (**NOTE TO APPLICANT:** If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)	☐	☐
If "YES":		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	☐	☐
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	☐	☐
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)	☐	☐
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?	☐	☐
(c) Was this your first time in this type of Medicare plan?	☐	☐
(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐	☐
4. (a) Do you have another Medicare supplement policy in force?	☐	☐
(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?	☐	☐
If existing Medicare supplement coverage is not to be replaced, this policy cannot be issued.		
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan)	☐	☐
(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?	☐	☐
If yes, give effective date of Part B: _____		
2. If Medicare Parts A and B are to be effective at a future date, provide the date both Medicare Parts A and B will be effective _____.		

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

SECTION VI - MEDICAL QUESTIONS

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

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

	YES	NO
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?	☐	☐
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?	☐	☐
3. Are you currently bedridden or do you use the assistance of a wheelchair, walker or motorized mobility aid?	☐	☐
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?	☐	☐
b. Been confined to a nursing facility for more than 30 days?	☐	☐
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?	☐	☐
d. Had a Stroke or Transient Ischemic Attack (TIA)?	☐	☐
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?	☐	☐
b. Major Depression, Bi-Polar Disorder, Schizophrenia or a Paranoid Disorder?	☐	☐
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?	☐	☐
d. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease or Lymphoma?	☐	☐
e. Alcohol or Drug Abuse?	☐	☐
f. Paralysis, Hemophilia, Osteoporosis with fractures, or un-repaired Aneurysm?	☐	☐
g. Paget's Disease, Rheumatoid or Disabling Arthritis, Lupus or other Connective tissue disorder?	☐	☐
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?	☐	☐
b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immuno-deficiency Virus (HIV) infection?	☐	☐
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?	☐	☐
d. Amputation caused by disease or organ transplant other than corneas?	☐	☐
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?	☐	☐
8. Has surgery been advised but not performed or any surgery anticipated, including cataract surgery?	☐	☐
9. Have medical tests, treatment, or therapy been advised but not performed?	☐	☐

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

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)

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

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

(a) Application Packet (Phone Sale Only)

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

(c) Outline of Medicare Supplement Coverage

(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.

Printed Name of 1st Licensed Agent	Signature of 1st Licensed Agent	Writing Number	Percentage
Mark Sheffield		HM05662	100%
Printed Name of 2nd Licensed Agent	Signature of 2nd Licensed Agent	Writing Number	Percentage

MEDICARE SUPPLEMENT INSURANCE PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER APPLIES TO
(must select one below):

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

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

Financial Institution Name and Telephone Number _____

Financial Institution Address _____

9 Digit Routing Number _____ Account Number _____

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

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

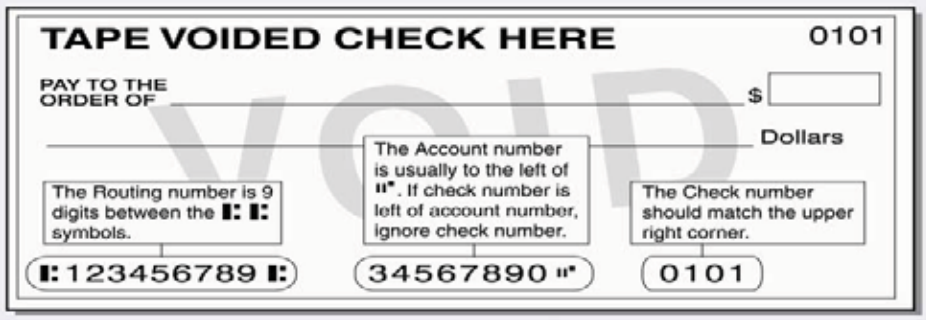
Type of Account:
☐ Personal Checking Account
☐ Personal Savings Account
☐ Corporate/Business Checking

Name of Employer Group_____

Purpose for Submitting this Authorization – Check appropriate box(es):
☐ New authorization
☐ Change in checking/savings account
☐ Change in financial institution
☐ Change in existing coverage

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

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



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.

GREAT AMERICAN. FINANCIAL RESOURCES
Supplemental Benefits Group

GASBG-9-0044 **01/10**

GREAT AMERICAN. FINANCIAL RESOURCES
Supplemental Benefits Group

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

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

DUPLICATION OF INSURANCE FORM

(Please select Company below)**:**

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

PLEASE READ CAREFULLY BEFORE SIGNING

I understand that the insurance I am applying for will duplicate coverage I already have. Even so, I still believe I need this new insurance.

_____ _____

Witness Signature of Applicant

_____

Date

GREAT AMERICAN®
FINANCIAL RESOURCES

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:

☐ Great American Life Insurance Company®
☐ United Teacher Associates Insurance Company
☐ Provident American Life & Health Insurance Company
☐ Loyal American Life Insurance Company®
☐ Central Reserve Life Insurance Company
☐ 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):

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ My plan has outpatient drug coverage and I am enrolling in Part D.

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

_____

☐ 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 Millitary Cutoff Rd #188, Wilmington, N

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):

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ My plan has outpatient drug coverage and I am enrolling in Part D.

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

_____

☐ 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 Millitary Cutoff Rd #188, Wilmington, N

Type or Print Name and Address of Agent or Broker

_____
Applicant's Signature

_____
Date