

APPLICATION for MEDICARE SUPPLEMENT INSURANCE

American Retirement Life Insurance Company

PO Box 5725, Scranton, PA 18505-5725 • Customer Service 866-459-4272 • www.HealthSpring.com

Phone Verification (PV) Hotline 866-825-4822 • FaxApp Submission 877-704-8186



Application is for: ☒ New business ☐ Reinstatement Phone verification case #(s) _____

› If you complete this application with another Applicant, you are consenting to the other Applicant viewing the protected health information that you provided on this application.

› If only one Applicant, complete Applicant A questions.

A. Personal information

APPLICANT A

Name (First MI Last)

Age

Date of birth (MM/DD/YYYY)

Gender

☐ Male ☐ Female

Resident address (Street, City, State ZIP)

Phone

()

Mailing address (if different from resident address)

Social Security no. (XXX-XX-XXXX)

Email address (optional) By providing your email address, you agree to receive marketing content electronically.

APPLICANT B

Name (First MI Last)

Age

Date of birth (MM/DD/YYYY)

Gender

☐ Male ☐ Female

Resident address (Street, City, State ZIP) – OR check box ☐ if same as Applicant A

Phone

()

Mailing address (if different from resident address)

Social Security no. (XXX-XX-XXXX)

Email address (optional) By providing your email address, you agree to receive marketing content electronically.

Premium Discount (see Outline of Coverage for details)

APPLICANT A
YES NO

APPLICANT B
YES NO

1. a. For the past 12 months have you lived with one to three adults that are ages 50+, your spouse, civil union partner, or domestic partner (6% "Household" premium discount)? ☐ ☐ ☐ ☐

b. If YES, do they have a Medicare Supplement policy with American Retirement Life Insurance Company or an affiliate of American Retirement Life Insurance Company (an 11% total premium "Multi-Insured" discount)? ☐ ☐ ☐ ☐

2. If you answered YES to 1a or 1b, please provide additional information if other than Applicant A or Applicant B.

Name (First MI Last)

Date of Birth (MM/DD/YYYY)

SSN or Policy # (Applicable if YES to 1b)

B. Please provide your Medicare information (as shown on your Medicare card)

APPLICANT A

Medicare number _____

Hospital (Part A) coverage starts (MM/DD/YYYY) _____

Medical (Part B) coverage starts (MM/DD/YYYY) _____

APPLICANT B

Medicare number _____

Hospital (Part A) coverage starts (MM/DD/YYYY) _____

Medical (Part B) coverage starts (MM/DD/YYYY) _____

Medicare Part A is hospital insurance. Medicare Part B is medical insurance. You must have both Medicare Parts A and B on your requested Medicare Supplement effective date for coverage to be issued.

C. Select a plan and effective date

APPLICANT A Check plan selected: ☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan HDG ☐ Plan N

APPLICANT B Check plan selected: ☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan HDG ☐ Plan N

Requested Medicare Supplement effective date (MM/DD/YYYY)

APPLICANT A _____ APPLICANT B _____

(if no effective date is requested, we will assign the 1st day of the month following the date of this application)

*Plan F is only available if you are first Medicare-eligible before 2020.

D. Are you eligible for Guaranteed Acceptance?

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed acceptance 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 within your application.**

Additional information regarding Guaranteed Issue, including the Open Enrollment timeframe, can be found in Section F. Important statements for Applicant to read.

PLEASE ANSWER ALL QUESTIONS (mark YES or NO below with an "X").

	APPLICANT A		APPLICANT B	
	YES	NO	YES	NO
To the best of your knowledge:				
1. a. Did you turn age 65 in the last six (6) months?	☐	☐	☐	☐
b. Did you enroll in Medicare Part B in the last six (6) months?	☐	☐	☐	☐
If YES, what is the effective date? (MM/DD/YYYY) A _____ B _____				
2. Are you covered for medical assistance through California's Medi-cal program? (Note to Applicant: if you have "share of cost", under Medi-Cal, please answer NO to this question.)	☐	☐	☐	☐
If YES,				
a. will Medi-cal pay your premiums for this Medicare Supplement policy?	☐	☐	☐	☐
b. do you receive any benefits from Medi-Cal 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 the END date blank).				
A START _____ END _____				
B START _____ END _____				
b. if you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	☐	☐	☐	☐
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?				
A _____				
B _____				
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.				

	APPLICANT A		APPLICANT B
	YES	NO	YES NO
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?			
A			
B			
b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave the END date blank.)			
A START END			
B START END			
6. Are you under age 65?	☐	☐	☐ ☐
If YES, do you have end-stage renal disease (ESRD) or kidney disease requiring dialysis?	☐	☐	☐ ☐

E. Complete medical questions

MEDICAL UNDERWRITING IS USED OUTSIDE OF OPEN ENROLLMENT OR GUARANTEED ISSUE.

IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE

DO NOT ANSWER THE QUESTIONS IN THIS SECTION.

It is important that you provide truthful and accurate answers to the questions in this section as your answers form the basis of our determination of your eligibility for this coverage. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage.

PART A. MEDICAL QUESTIONS – If the answer to any question in Part A is YES, you are not eligible for coverage.

	APPLICANT A		APPLICANT B			
	YES	NO	NOT SURE	YES	NO	NOT SURE
1. Are you confined, scheduled for admission, or in the last two (2) years have you been confined to a nursing facility or assisted living facility?	☐	☐	☐	☐	☐	☐
2. Do you receive home health care services; or in the last two (2) years, have you received home health care services for more than three (3) separate periods of care?	☐	☐	☐	☐	☐	☐
3. Do you have a terminal illness; are you in the hospital, pending hospital admission, or have you been hospitalized more than two (2) times in the last two (2) years?	☐	☐	☐	☐	☐	☐
4. Do you receive assistance bathing, transferring, toileting, eating, dressing, or are you bedridden; have you been advised by a medical professional to use the assistance of a wheelchair, walker, or motorized mobility aid?	☐	☐	☐	☐	☐	☐
5. Within the past six (6) months, have you been treated for or advised by a medical professional to have treatment for diabetes with hypertension that required three (3) or more hypertension medications to control or diabetes requiring more than 50 units of insulin daily to control? ...	☐	☐	☐	☐	☐	☐
6. Within the past two (2) years have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following: ...	☐	☐	☐	☐	☐	☐
• heart attack, congestive heart failure, coronary bypass, angioplasty, atherosclerosis or arteriosclerosis, peripheral vascular disease, carotid artery disease, coronary artery disease (CAD), angina, cardiomyopathy, stent placement, heart valve surgery, atrial fibrillation, irregular heartbeat, cardiac pacemaker, transient ischemic attack (TIA) or stroke? (You should answer NO if your only treatment has been less than three concurrent cardiovascular medications and your treatment has not altered in the last two (2) years (e.g., change in medications or dosage increases)).						

PART A. MEDICAL QUESTIONS (cont'd.)

	APPLICANT A			APPLICANT B		
	YES	NO	NOT SURE	YES	NO	NOT SURE
7. At any time, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following:	☐	☐	☐	☐	☐	☐
• muscular dystrophy, multiple sclerosis, or amyotrophic lateral sclerosis (Lou Gehrig's disease)?						
• Paget's disease, rheumatoid arthritis, disabling arthritis, osteoporosis with fractures, or paralysis?						
• chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, cirrhosis of the liver or any condition requiring an organ transplant?						
• bipolar disorder, schizophrenia, a paranoid disorder, severe depression, or treatment for depression with medication for two (2) or more years?						
• organic brain disorder?						
• unrepaired aneurysm, hemophilia, or any other blood disorder?						
• any heart disease requiring a permanent, implantable cardiac defibrillator?						
• chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), emphysema, chronic bronchitis or other chronic lung or respiratory disorder not listed that requires the permanent use of oxygen?						
• diabetes with neuropathy, diabetes with retinopathy, or diabetes with vascular disease?						
• cerebral palsy, myasthenia gravis, systemic lupus, Parkinson's disease?						
• hepatitis other than hepatitis A or other liver disease?						
• dementia, senility or Alzheimer's disease?						
• PSA levels greater than 6.0?						
8. Within the past two (2) years, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following:	☐	☐	☐	☐	☐	☐
• any cancer, excluding skin cancer (except malignant melanoma)?						
• anemia requiring repeated blood transfusions?						
• alcohol or drug abuse (including counseling)?						
• pancreatitis?						
• seizure?						
9. At any time, have you been treated for or advised by a medical professional to have treatment for an amputation caused by disease, or for an organ transplant (other than corneas)?	☐	☐	☐	☐	☐	☐
10. Have medical tests, treatment, therapy, or surgery been advised but not performed or is any surgery anticipated? (This excluded mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only.)	☐	☐	☐	☐	☐	☐
11. Have you ever been diagnosed with or received medical advice or treatment from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐	☐	☐	☐	☐

If you answered NO to all questions in this Section, please continue to Part B. >>>

PART B. HEIGHT/WEIGHT, TOBACCO, AND PRESCRIPTION MEDICATIONS – The answers to questions in Part B are subject to the Company's underwriting review and may result in a decline. Please provide complete details as requested.

12. **APPLICANT A** Height (ft.-in.) _____ Weight (lbs.) _____
APPLICANT B Height (ft.-in.) _____ Weight (lbs.) _____

13. Have you used tobacco within the last 12 months*..... ☐ ☐ ☐ ☐ ☐ ☐

*Answering this question is voluntary. American Retirement Life Insurance Company offers rates for non-tobacco users. In order to take advantage of the reduced rates, you must answer this question.

PART B. HEIGHT/WEIGHT, TOBACCO, AND PRESCRIPTION MEDICATIONS QUESTIONS (*cont'd.*)

14. Please list any prescription medications taken or prescribed in the past to (2) years (*attach a separate sheet if needed*).

[illegible]

F. 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 Medi-Cal and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, 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 Medi-Cal 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 Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare Supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.
- A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's internet website (www.insurance.ca.gov).
- **Guaranteed Issue:**
Your main open enrollment for a Medigap (Medicare Supplement) policy is a one-time 6-month period starting the first day of the month you are age 65 or older and enrolled in Medicare Part B. You have the right to purchase certain Medigap policies outside of your main open enrollment period in specific circumstances. In these circumstances, we must sell you one of the required Medicare Supplement policies at the best price for your age, without a waiting period or health screening. The Guaranteed Issue period begins on the later of the date your coverage ends or the date you receive notice of your termination of coverage and ends 63 days after the coverage terminates. You have an annual right to switch Medicare Supplement plans and avoid medical underwriting (the California Birthday Rule). The new plan must have equal or lesser benefits than the current plan, and it can be purchased from any insurance carrier. Policyholders will be notified of this right at least 30 days (but no more than 60 days) before their birthday and have an open enrollment window for 60 days following their birthday.
- **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. This applies whether or not the insurer medically underwrites or asks health-related questions.**

As an alternative to court action, any matter in dispute between me and the Company may be subject to binding arbitration governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association. Any decision reached by arbitration shall be binding upon both myself and the Company and may be entered as a judgment in any court of proper jurisdiction. By signing this application, I acknowledge that I am giving up the right to a trial in court, both with and without a jury.

I hereby apply to American Retirement Life Insurance 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) a policy has been issued by the Company and (b) the initial premium has been paid; 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*.

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.

For your protection California law requires the following statement to appear on this form.

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 fines and confinement in prison.

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

APPLICANT A Telephone number _____ Best time to call _____

APPLICANT B Telephone number _____ Best time to call _____

I understand that the Medicare Supplement policy applied for will not cover loss due to Pre-Existing Condition(s) unless the expense for that loss is incurred more than six (6) months after the effective date of coverage. This provision does not apply if, as of the date of application, you had a Continuous Period of Creditable Coverage which did not expire more than 63 days ago and such coverage, while in force, lasted for at least six (6) months. If, as of the date of application, you had less than six (6) months prior Creditable Coverage, the Pre-Existing Conditions limitation will be reduced by the aggregate amount of Creditable Coverage. If this policy is replacing another Medicare Supplement policy, credit will be given for any portion of the waiting period that has been satisfied. This provision does not apply if you are applying for and are issued this policy under Guaranteed Issue status.

APPLICANT A Signature _____ Date _____

APPLICANT B Signature _____ Date _____

G. Determine your rate class

A B

☐ ☐ **Preferred** If you're eligible for Open Enrollment/Guaranteed Issue or answered NO to section E, question 13.

☐ ☐ **Standard** If you answered YES to section E, question 13.

Your eligibility for coverage and final rate class is subject to underwriting review.

H. Choose your method of payment

APPLICANT A

Method (select one of the following):

☐ Bank draft (complete the Electronic Funds Transfer Agreement)

☐ Direct bill (enclose check payable to American Retirement Life Insurance Company; do not send cash)

☐ List bill Group name _____ Group number _____

Mode: ☐ Monthly (bank draft or list bill only) ☐ Quarterly ☐ Semi-annually ☐ Annually

Premium (see rate chart in Outline of Coverage) \$ _____

If you answered YES to Section A, question 1a, and NO to 1b, multiply premium by 0.94.

If you answered YES to Section A, questions 1a and 1b, multiply premium by 0.89.

APPLICANT B

Method (select one of the following):

☐ Bank draft (complete the Electronic Funds Transfer Agreement)

☐ Direct bill (enclose check payable to American Retirement Life Insurance Company; do not send cash)

☐ List bill Group name _____ Group number _____

Mode: ☐ Monthly (bank draft or list bill only) ☐ Quarterly ☐ Semi-annually ☐ Annually

Premium (see rate chart in Outline of Coverage) \$ _____

If you answered YES to Section A, question 1a, and NO to 1b, multiply premium by 0.94.

If you answered YES to Section A, questions 1a and 1b, multiply premium by 0.89.



Agent use only

Please answer all questions:

1. I certify that I have provided the Applicant(s) with the following documents:

- a. Application packet (*phone sales only*) b. *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(s) (*check all that apply; must select at least one*):

Date _____ ☐ In person ☐ Mail ☐ Email ☐ Fax ☐ Other (*explain*) _____

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

APPLICANT A: ☐ YES ☐ NO APPLICANT B: ☐ YES ☐ NO

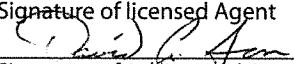
If YES, give name of company, reason, and termination date:

A _____

B _____

NOTES: Please provide additional information that may assist in processing this application (*attach a separate sheet if needed*).

I certify that I have interviewed the Applicant(s), 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(s).

Printed name of licensed Agent DAVID A. ION	Signature of licensed Agent 	Writing number 157857	Percentage 100
Printed name of 2 nd licensed Agent	Signature of 2 nd licensed Agent	Writing number	Percentage