

**HOME OFFICE USE ONLY**

OE  Underwritten  
 GI  Disabled (underage)

**American Continental Insurance Company**  
A Genworth Financial Company  
101 Continental Place • Brentwood, Tennessee 37027

**APPLICATION FOR  
MEDICARE SUPPLEMENT  
INSURANCE POLICY**

**PART I - APPLICATION INFORMATION**

|   |  |                                      |   |                               |  |
|---|--|--------------------------------------|---|-------------------------------|--|
| <b>1. Primary Proposed Insured</b> (please print full name)   |  |                                      | <b>9. Plan</b> <input type="checkbox"/> Standard<br><b>Plan Selected:</b> _____ |                               |  |
| <b>2. Address</b>   |  |                                      | Date enrolled in Medicare Part A _____  |                               |  |
| Street or R.F.D. _____  |  |                                      | Date enrolled in Medicare Part B _____  |                               |  |
| City _____  |  | State _____                          | Zip Code _____  |                               |  |
| Telephone Number _____  |  | E-mail Address _____                 |   |                               |  |
| <b>3. Medicare Card No.</b>                                   | <b>4. Social Security No.</b>  | <b>5. Birth Date and Place</b>       |   |                               |  |
|   |  | Month                                | Day   | Year                          | State  |
| <b>6. Age</b>   | <b>7. Sex</b> <input type="checkbox"/> Male<br><input type="checkbox"/> Female | <b>8. Height</b> ft. _____ in. _____ |   |                               | <b>Weight</b> lbs. _____   |
| <b>Do not complete if Open Enrollment or Guaranteed Issue</b> |  |                                      |   |                               | <b>10. Premium:</b> \$ _____   |
|   |  |                                      |   |                               | <b>Policy Fee:</b> \$ _____  |
|   |  |                                      |   |                               | <b>Total Collected:</b> \$ _____   |
|   |  |                                      |   |                               | <b>Premium Mode:</b> <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual<br><input type="checkbox"/> Quarterly <input type="checkbox"/> Bank Service Plan |
| <b>11. Beneficiary:</b> First _____                           |  | Contingent Beneficiary _____         |   |                               |  |
| Name _____  |  | Relationship _____                   |   | Name _____ Relationship _____ |  |

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. To the best of your knowledge:

|  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| <b>12. (a)</b> Did you turn age 65 in the last 6 months? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>(b)</b> Did you enroll in Medicare Part B in the last 6 months? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>(c)</b> If yes, what is the effective date? .....   |                          |                          |
| <b>13.</b> 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.) .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes,  |                          |                          |
| <b>(a)</b> Will Medicaid pay your premiums for this Medicare supplement policy? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>(b)</b> Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>14. (a)</b> If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.<br>START ____/____/____ END ____/____/____ |                          |                          |
| <b>(b)</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"/> |
| <b>(c)</b> Was this your first time in this type of Medicare plan? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>(d)</b> Did you drop a Medicare supplement policy to enroll in the Medicare plan? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>15. (a)</b> Do you have another Medicare supplement policy in force? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>(b)</b> If so, with what company, and what plan do you have? .....  |                          |                          |
| <b>(c)</b> If so, do you intend to replace your current Medicare supplement policy with this policy? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>16.</b> 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"/> |
| <b>(a)</b> If so, with what company, and what kind of policy? .....  |                          |                          |
| <b>(b)</b> What are your start and end dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.) START ____/____/____ END ____/____/____   |                          |                          |

**PART II - ELIGIBILITY QUESTIONS**

IF ANY ANSWER TO A QUESTION IN PART II IS "YES," THE PROPOSED INSURED IS NOT ELIGIBLE FOR COVERAGE. IF YOU ARE APPLYING FOR COVERAGE DURING OPEN ENROLLMENT, OR ON A GUARANTEED ISSUE BASIS, DO NOT ANSWER QUESTIONS 17-19.

|   |                          |                          |
|---|--------------------------|--------------------------|
| <b>17.</b> Are you currently confined to a hospital, nursing facility, or any other facility regardless of type, bed confined or do you use a wheelchair or any motorized mobility device or need assistance with daily living? ..... | YES                      | NO                       |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>18.</b> Have you been medically diagnosed with, received medical advice, treatment, or surgery for or been told by a medical professional that you need treatment or surgery for the following conditions:                         |                          |                          |
| <b>A.</b> at any time for:  |                          |                          |
| 1) Congestive heart failure, implantation of a defibrillator, unoperated aneurysm, leukemia, Hodgkin's Disease, lymphoma, or cirrhosis? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, or cerebral palsy? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Kidney failure, renal insufficiency, kidney disease requiring dialysis, Addison's Disease, or any condition requiring an organ transplant? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>B.</b> within the past three (3) years for alcoholism, drug abuse, anemia requiring repeated blood transfusions, any other blood disorder, internal cancer, melanoma, hepatitis, or disorder of the pancreas? .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>C.</b> within the past two (2) years for:  |                          |                          |
| 1) Enlarged heart, stroke, transient ischemic attack (TIA), peripheral vascular disease, or peripheral neuropathy? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Any lung or respiratory disorder requiring the use of a nebulizer, 3 or more medications, or oxygen therapy? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Systemic lupus or any connective tissue disorder, arthritis restricting mobility or the activities of daily living, osteoporosis with fractures, or Paget's Disease? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Insulin dependent diabetes, uncontrolled diabetes, complications of diabetes, or amputation caused by any disease? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>D.</b> within the past one (1) year for heart attack, artery blockage, heart valve disorder, or uncontrolled hypertension? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>19.</b> Have you within the past one (1) year:   |                          |                          |
| <b>A.</b> had a pacemaker implanted? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>B.</b> had a PSA blood test result greater than 4.5; unless you are 70 or over, then greater than 6.5? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>C.</b> had a seizure? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

**PART III**

**IF ANY ANSWER TO A QUESTION IN PART III IS "YES" COVERAGE MAY BE CONSIDERED.**

**IF YOU ARE APPLYING FOR COVERAGE DURING OPEN ENROLLMENT, OR ON A GUARANTEED ISSUE BASIS, DO NOT ANSWER QUESTIONS 20-25.**

- 20. Have you been medically diagnosed and advised by a medical professional to have tests, surgery, treatment or further evaluation that has not been performed, or are there any test results pending? .....  YES  NO
- 21. Within the past 90 days, have you received any home health care or physical therapy? .....  YES  NO
- 22. Have you within the past two (2) years been medically diagnosed with, received medical advice, treatment, or surgery for or been told by a medical professional that you need treatment for the following conditions: brain, mental or nervous disorders? .....  YES  NO
- 23. Are you taking or have you been medically advised to take any prescribed medications? .....  YES  NO
- 24. Within the past two years have you been hospitalized, treated at an outpatient facility, or emergency room? .....  YES  NO
- 25. Have you used any tobacco products in the past 12 months? .....  YES  NO

**Details of "Yes" Answers in 20-25. If more space is needed, use adjacent page.**

| Date | Type of Injury or Illness | Doctor/Hospital & Address | Fully Recovered? | Medication Taken |
|------|---------------------------|---------------------------|------------------|------------------|
|      |                           |                           |                  |                  |
|      |                           |                           |                  |                  |
|      |                           |                           |                  |                  |
|      |                           |                           |                  |                  |
|      |                           |                           |                  |                  |
|      |                           |                           |                  |                  |

**Your Primary Physician**

Dr. \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_

**Physician or Specialist Seen in the Past 2 Years**

Dr. \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_

**PART IV - IMPORTANT STATEMENTS TO BE READ -**

(1) You do not need more than one Medicare supplement policy. (2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. (3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. (4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be 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. (5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be 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. (6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

**AGENT:** Please list any other medical or health insurance policies sold to the Proposed Insured.

- 1) List policies sold which are still in force: \_\_\_\_\_
- 2) List policies sold in the past 5 years which are no longer in force: \_\_\_\_\_

**PART V**

**26. A recorded interview may be necessary as part of the underwriting on your application for insurance.**

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Best time to call:  8AM - Noon  Noon - 4:30 PM

**27. I hereby acknowledge that I have received, read and understood the enclosed information as evidenced by my signature below:**

- Notice Regarding Use of Medical Information Bureau  Outline of Coverage  Guide to Health Insurance for People with Medicare
- HIPAA Privacy Rule - Authorization for Release of Health-Related Information  Replacement Notice (if applicable)

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

**NOTICE TO AGENT: ALL Proposed Insureds MUST sign the Authorization for Release of Health-Related Information.**

I represent that my above answers and statements are true and complete to the best of my knowledge and belief and agree that no insurance will be effective unless a policy is issued.

Signed at \_\_\_\_\_ Date \_\_\_\_\_ X \_\_\_\_\_  
City and State Signature of Proposed Insured

I certify that I have personally interviewed the proposed applicant, asked all of the questions as written on the application, and I have truly and accurately recorded in the application the information supplied by the applicant.

Agent's Name (print or type) \_\_\_\_\_ ACI Agent Number \_\_\_\_\_ E-mail: \_\_\_\_\_

Agent's Signature \_\_\_\_\_ State License ID No. \_\_\_\_\_

Agent's Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_

|   |   |                               |   |   |  |  |  |
|---|---|-------------------------------|---|---|--|--|--|
| Premium Mode: <input type="checkbox"/> BSP <input type="checkbox"/> Qrtly. <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual |   |                               |   | Requested Medicare Supplement Effective Date: ____/____/____<br>(must be after date of application) |  |  |  |
| <b>PLAN</b><br>Medicare Supplement  | <b>PREMIUM NOT INCLUDING POLICY FEE</b><br>\$ _____ | <b>POLICY FEE</b><br>\$ _____ | <b>TOTAL PREM. COLLECTED INCLUDING POLICY FEE</b><br>\$ _____ |   |  |  |  |
| <b>TOTAL PREMIUM COLLECTED INCLUDING POLICY FEE(S) \$ _____</b>   |   |                               |   | SEND POLICY TO: <input type="checkbox"/> AGENT <input type="checkbox"/> INSURED                     |  |  |  |

***Congratulations on your good judgment!***

**RECEIPT FOR PAYMENT OF PREMIUMS**

RECEIVED FROM \_\_\_\_\_ the sum of \$ \_\_\_\_\_ this day of \_\_\_\_\_, 20\_\_\_\_ and an application for insurance.

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

**All premium checks must be made payable to the Company.  
DO NOT make any check payable to the agent or leave the payee blank on the check.**

Agent's Signature \_\_\_\_\_

Pre-authorized Bank Service Plan is the modern way to pay insurance premiums. Payments on time, for correct amount . . . no unintentional lapse of protection. No checks to make out. No postage stamps to bother with. No premium notices to return. A VOIDED CHECK (A DEPOSIT SLIP IS NOT SUFFICIENT) AND SIGNED AUTHORIZATION ARE ALL THAT ARE REQUIRED TO ACTIVATE A BSP. Renewal premiums may be drafted on MONTHLY, QUARTERLY, SEMI-ANNUAL, or ANNUAL Modes. Multiple policies may be drafted on the SAME draft.

**IMPORTANT NOTICE TO AGENTS — Attach sample copy of Applicant's check (deposit slip not acceptable).**

**BANK SERVICE PLAN  
(BSP)**

The Applicant may pay (at the option of the Company) future premiums by bank check through the Applicant's own checking account. This convenient method of premium payment is preferred by most policyowners. Be sure Applicant signs the Bank Check Authorization with his/her USUAL BANK SIGNATURE.

**AUTHORIZATION TO HONOR DRAFTS OR MAGNETIC TAPE DEBITS  
DRAWN BY  
AMERICAN CONTINENTAL INSURANCE COMPANY**

To: \_\_\_\_\_  
Your Bank's (NAME OF YOUR BANK)

Address: \_\_\_\_\_  
As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of American Continental Insurance Co., provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of American Continental Insurance Co. to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

\_\_\_\_\_ X \_\_\_\_\_  
Date Your signature EXACTLY as it appears on Bank Records Acct. No.

**OTHER IMPORTANT INFORMATION  
PRODUCER COMPENSATION**

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

**MIB, INC. PRE-NOTICE**

Information regarding your insurability will be treated as confidential. American Continental Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

American Continental Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**INVESTIGATIVE CONSUMER REPORT NOTICE**

Thank you for your application. As part of our underwriting procedure, a routine investigative consumer report may be made during the next few days. This report typically concerns information on an applicant's character, general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation. This information will be obtained through personal interviews with your friends, neighbors and associates. You have the right to be interviewed as part of the investigation and receive a copy of the report. We will be pleased to provide you with further information on the nature and scope of such a report, if one is made, upon receipt of your written request. Should you wish to contact us about questions you may have, please write to: **AMERICAN CONTINENTAL INSURANCE COMPANY, 101 Continental Place, Brentwood, Tennessee 37027**