COMPANION
WHOLE LIFE INSURANCE
Insured by American Retirement Life Insurance Company

Application Booklet for
WHOLE LIFE *in* NORTH DAKOTA

- APPLICATION
- ELECTRONIC FUNDS TRANSFER AGREEMENT
- MIB PRE-NOTICE
- HIPAA NOTICE
- NOTICE AND CUSTOMER INFORMATION FORM
- LIFE REPLACEMENT NOTICE

BEING TRUE TO **YOURSELF**
IS THE FIRST STEP TO
BEING TRULY **HEALTHY.**

GO YOU®

Cigna®

AMERICAN RETIREMENT LIFE INSURANCE COMPANY
11200 Lakeline Blvd., Suite 100, Austin, TX 78717
Mailing address: PO Box 559015, Austin, TX 78755-9015

Whole Life Insurance Application

☐ NEW BUSINESS ☐ REINSTATEMENT **PV Case #**_____

Requested Effective Date _____ (if no Date, we will assign the approval date as the Effective Date of the Application)

SECTION I: APPLICANT INFORMATION (PLEASE PRINT)

Name of Applicant First	MI	Last	Age	Date of Birth MM	DD	YYYY	State of Birth

Resident Street Address (no PO Box) _____

City _____ **State** _____ **Zip** _____

Mailing Address (if different from above) _____

City _____ **State** _____ **Zip** _____

Phone ( ) _____ **Email Address** _____

Social Security No.	Sex M/F	Height Ft.	In.	Weight Lbs.	Have you used tobacco within the last 12 months?
– –					Yes ☐ No ☐

SECTION II: BILLING

Method (select one of the following):

☐ Direct Bill

☐ Bank Draft (complete the EFT Agreement)

Mode (select one of the following):

☐ Monthly (n/a with Direct Bill)

☐ Quarterly

☐ Semi-annually

☐ Annually

SECTION III: WHOLE LIFE COVERAGE APPLIED FOR

Whole Life Insurance: Benefit Amount $_____

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship

Owner, if other than the Proposed Insured Name	Relationship	Social Security No. – –

Address _____

SECTION IV: TOTAL PREMIUM WITH APPLICATION

Initial premium: ☐ Draft bank account ☐ Check enclosed (payable to ***American Retirement Life Insurance Company)***

*Modal Premium includes a $36 annual policy fee

Policy Modal Premium* $_____

Total Premium with Application $_____

SECTION V: LIFE REPLACEMENT

1) Will you be replacing any existing life insurance or annuity? ..... **YES** ☐ **NO** ☐

If "YES", please provide existing Insurance Company Name and Address _____

_____

2) **AGENT PROVIDED SALES MATERIAL STATEMENT** (MUST BE COMPLETED BY THE AGENT ONLY IF THE APPLICANT IS REPLACING EXISTING LIFE INSURANCE OR ANNUITY): I hereby certify that in connection with my presentation to the Applicant herein, I only used sales materials that were previously approved by American Retirement Life Insurance Company and that I left with or provided to the Applicant a copy of the sales materials used in my presentation to the Applicant.

Agent's Signature / Printed Name _____ Date _____

SECTION VI: MEDICAL QUESTIONS

PLEASE ANSWER ALL 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", 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 bathing, transferring, toileting, eating, or dressing?	☐	☐
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 diagnosed with a terminal illness or been hospitalized more than two (2) times, received home health care services more than three (3) times, or been confined to a nursing facility for more than thirty (30) days?	☐	☐
b) been diagnosed with or treated (other than with maintenance medication) for angina, heart attack, atrial fibrillation, cardiomyopathy, congestive heart failure, cardiac or vascular angioplasty, stent placement, peripheral vascular disease, coronary bypass, carotid artery disease, coronary artery disease, or heart disease; had heart or heart valve surgery or required the implantation of cardiac pacemaker or defibrillator?	☐	☐
c) 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 (other than hepatitis A), cirrhosis of the liver, or other liver disease?	☐	☐
b) major depression, bipolar disorder, schizophrenia, or a paranoid disorder?	☐	☐
c) diabetes requiring more than 50 units of insulin daily to control or diabetes with any of the following: neuropathy, retinopathy, vascular disease, or hypertension requiring more than two medications to control?	☐	☐
d) chronic kidney disease, Addison's Disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant?	☐	☐
e) internal cancer, leukemia, malignant melanoma, Hodgkin's Disease, or lymphoma?	☐	☐
f) alcohol or drug abuse?	☐	☐
g) paralysis, hemophilia, osteoporosis with fractures, or unrepaired aneurysm?	☐	☐
h) Paget's Disease, rheumatoid or disabling arthritis, systemic 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) emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic Obstructive Lung Disease (COLD), or any chronic lung or respiratory disorder requiring the use of oxygen?	☐	☐
c) amputation caused by disease or organ transplant other than corneas?	☐	☐

	YES	NO
7) 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), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection?	☐	☐
8) 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, or any other blood disorder?	☐	☐
9) Has surgery been advised but not performed or is any surgery anticipated, including but not limited to joint replacement or cataract surgery?	☐	☐
10) Have medical tests (other than mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only), treatment, or therapy been advised but not performed?	☐	☐

PART B: MEDICAL QUESTIONS - If the answer to any of the following questions is "YES", you might be eligible for coverage. Please provide complete details as requested below.

	YES	NO
11) Within the past two (2) years, have you been declined for Life, Health, or Supplemental Insurance? ..... If "YES", please provide details including the date of the declination, the type of coverage applied for, and the reason for the declination here:	☐	☐
12) In the past two (2) years, have you had PSA levels greater than 6.0 or been diagnosed with dysplasia of the cervix classified as a level 3.0 or higher? ..... If "YES", please provide details in the table below.	☐	☐

Test	Results	Diagnosis

13) Within the past two (2) years, have you taken any medication for any heart or vascular disease other than hypertension? ..... If "YES" or if you are taking any medications, give complete details in Part C Medications.	☐	☐

PART C: MEDICATIONS

14) Please list any prescription medications taken or prescribed in the past two (2) years.
If you are not taking any medications, please check here: ☐ I am not taking any medications.

Medication	Dates Taken	Condition Taken for

AGENT NOTES - Please provide any other information that you believe may assist in our underwriting determination:

SECTION VII: IMPORTANT STATEMENTS FOR APPLICANT TO READ

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 MIB Pre-Notice.

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.

I ☐ ***grant*** ☐ ***do not grant*** my authorization to receive information or presentation of materials describing other insurance products.

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.

Telephone Number ( ) _____ Best time to call _____

Applicant's Printed Name _____

Signature of Applicant _____ Date _____

SECTION VIII: AGENT(S) CERTIFICATION

Do you have knowledge or reason to believe the replacement of existing insurance may be involved? YES ☐ NO ☐

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
Printed Name of 2nd Licensed Agent	Signature of 2nd Licensed Agent	Writing Number	Percentage

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

AMERICAN RETIREMENT LIFE INSURANCE COMPANY® • PO 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 - 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 American Retirement Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize American Retirement Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event American Retirement Life Insurance Company mistakenly deposits funds into my account, I authorize American Retirement Life Insurance to debit my account for an amount not to exceed the original amount of credit. 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 AMERICAN RETIREMENT LIFE INSURANCE COMPANY: 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 association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by American Retirement Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by American Retirement Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by American Retirement Life Insurance Company 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**

MIB, Inc., Pre-Notice

AMERICAN RETIREMENT LIFE INSURANCE COMPANY®
PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

Information regarding your insurability will be treated as confidential. American Retirement Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, 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. 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 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

American Retirement Life 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

AUTHORIZATION FORM FOR DISCLOSURE 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 American Retirement Life Insurance Company®.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., 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. However, MIB, Inc., information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB, Inc.
4. 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.
5. 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 Office at PO Box 26580, Austin, Texas 78755-0580.
6. 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.
7. 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 re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
8. 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.
9. 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.

American Retirement Life Insurance Company®

PO Box 559015, Austin, TX 78755-9015 • 866-459-4272

Notice and Customer Information Form

To help the government fight the funding of terrorism and money laundering activities, Federal law requires us to obtain all relevant customer-related information necessary to run an effective anti-money laundering program.

What this means to you: When submitting an application/order ticket/request form, we ask that the producer obtain the client's name, street address, date of birth, tax identification number, and other customer-related information that will allow us to identify the customer and fulfill our obligations under Federal law. Picture documentation, such as a driver's license or other identifying documents, will be used to verify the information given at the time of the sale.

By acknowledging receipt of this Notice and Customer Information Form, the undersigned authorizes any law enforcement agency, public or private institution, information service bureau, or other entity contacted by the Company identified above to furnish information sufficient to confirm the personal information of the undersigned as required by Federal law. This information is confidential and will not be used for any other purpose. The undersigned hereby releases all persons, agents and agencies, and entities providing confirming information from any and all liability arising out of the request for or the release of confirming information.

The owner information section must be completed in its entirety. If identification documents are not available, the customer must sign the form and the information will be verified by the Company.

The following information must be obtained for each tax identification number or social security number disclosed on the application for insurance.

I. **Owner**

FEIN/SSN	**Owner Name**	**Verification of ID** ☐ Driver's License/State ID ☐ Passport ☐ Other _____ ☐ Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)	**State/Country**	
Date of Birth	**Occupation**		**Number**	
Employer			**Date Issued**	**Exp. Date**

Additional Owner

FEIN/SSN	**Person's Name**	**Verification of ID** ☐ Driver's License/State ID ☐ Passport ☐ Other _____ ☐ Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)	**State/Country**	
Date of Birth	**Occupation**		**Number**	
Employer			**Date Issued**	**Exp. Date**

II. The source of funds for this transaction is _____

III. The purpose of this transaction is _____

Agent: I have examined and verified the customer's ID as noted above is true and correct to the best of my knowledge and belief.

_____ _____

Agent's Printed Name Agent Number

_____ _____

Agent's Signature Date

---------- **COMPLETE THIS PORTION ONLY IF THE APPLICANT DOES NOT HAVE IDENTIFICATION DOCUMENTS** ----------

Customer(s): I acknowledge the foregoing notice and certify that the foregoing information is true and correct to the best of my knowledge and belief.

_____ _____

Owner's Printed Name Owner's Signature Date

_____ _____

Additional Owner's Printed Name Additional Owner's Signature Date

American Retirement Life Insurance Company®
Home Office: 1300 East Ninth Street, Cleveland, OH 44114
Administrative Office: PO Box 559015, Austin, TX 78755-9015
Customer Service: 866-459-4272

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

Are you thinking aout buying a new policy and discontinuing or changing an existing policy? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy.

Make sure you understand the facts. Ask the company or agent that sold you your existing policy to provide you with a policy summary statement.

The reverse side contains a checklist of some of the items you should consider in making your decision. TAKE TIME TO READ IT.

Do not let one agent or insurer prevent you from obtaining information from another agent or insurer which may be to your advantage.

Hear both sides before you decide. This way, you can be sure you are making a decision that is in your best interest.

We are required to notify your existing company that you may be replacing their policy.

POLICY # _____ AMOUNT _____ ISSUE DATE _____

_____ _____
Applicant's Signature **Date**

_____ _____
Agent's Signature **Date**

_____
Existing Insurer

ITEMS TO CONSIDER

1) If the new policy coverages are basically similar, premiums for a new policy may be higher because rates increase as your age increases.

2) Cash value and dividends, if any, may grow slower under a new policy initially because of the initial cost of issuing a policy.

3) Your present insurance company may be able to make a change on terms which may be more favorable than if you replace existing insurance with new insurance.

4) If you borrow against an existing policy to pay premiums on a new policy, death benefits payable under your existing policy will be reduced by the amount of any unpaid loan, including unpaid interest.

5) Current interest rates are not guaranteed. Guaranteed interest rates are usually considerably lower than current rates. What rates are guaranteed?

6) Are premiums guaranteed or subject to change — up or down?

7) Participating policies pay dividends that may materially reduce the cost of insurance over the life of the contract. Dividends, however, are not guaranteed.

8) CAUTION: You are urged not to take action to terminate, assign, or alter your existing life insurance coverage until after you have been issued the new policy, examined it, and found it to be acceptable to you.

AND

REMEMBER: You have twenty (20) days following receipt of any individual life insurance policy to examine its contents. If you are not satisfied with it for any reason, you have the right to return it to the insurer at its home or branch office or to the agent through whom it was purchased for a full refund of premium.

American Retirement Life Insurance Company®
Home Office: 1300 East Ninth Street, Cleveland, OH 44114
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We are required to notify your existing company that you may be replacing their policy.

POLICY # _____ AMOUNT _____ ISSUE DATE _____

_____ _____
Applicant's Signature **Date**

_____ _____
Agent's Signature **Date**

_____
Existing Insurer

ITEMS TO CONSIDER

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AND

REMEMBER: You have twenty (20) days following receipt of any individual life insurance policy to examine its contents. If you are not satisfied with it for any reason, you have the right to return it to the insurer at its home or branch office or to the agent through whom it was purchased for a full refund of premium.

Cigna Medicare Supplement Solutions®

Insured by American Retirement Life Insurance Company

Application Booklet for
NORTH DAKOTA

BEING TRUE TO
YOURSELF
IS THE FIRST STEP
TO BEING TRULY
HEALTHY.

Note: All Applications outside of OE/GI require a Phone Verification (PV) – Reduce delays and make the PV call at the point-of-sale. **Call our PV Hotline at 866.825.4822 from 8 a.m. to 6 p.m. Central Time.**

GO YOU®

Cigna®

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

AMERICAN RETIREMENT LIFE INSURANCE COMPANY

11200 Lakeline Blvd., Suite 100, Austin, TX 78717
Mailing address: PO Box 559015, Austin, TX 78755-9015

Application is for: ☐ New Business ☐ Underwritten ☐ OE ☐ GI ☐ Reinstatement ☐ Benefit Change

Requested Medicare Supplement Effective Date*: _____ **PV Case #** _____
*note: if no Effective Date is requested, we will assign the 1st day of the month following the date of this Application

SECTION I: APPLICANT INFORMATION (PLEASE PRINT)

Name of Applicant			Age	Date of Birth			State
First	MI	Last		MM	DD	YYYY	of Birth

Resident Street Address (no PO Box) _____

City _____ **State** _____ **Zip** _____

Mailing Address (if different from above) _____

City _____ **State** _____ **Zip** _____

Phone ( ) _____ **Email Address** _____

Medicare Card No.	Social Security No. – –	Sex M/F	Height Ft.	In.	Weight Lbs.

Have you used tobacco within the last 12 months? ☐ Yes ☐ No **Rate Class:** ☐ Non-Tobacco ☐ Tobacco

SECTION II: COVERAGE APPLIED FOR

Check plan selected: ☐ Plan A ☐ Plan F ☐ Plan G ☐ Plan N

SECTION III: BILLING

Method (select one of the following):
☐ Direct Bill
☐ Bank Draft (Complete the Electronic Funds Transfer Agreement)

Mode (select one of the following):
☐ Monthly (not available with Direct Bill)
☐ Quarterly
☐ Semi-annually
☐ Annually

SECTION IV: BILLING TOTALS

☐ Draft bank account for initial premium* ☐ Check enclosed for initial premium*
(Make check payable to ***American Retirement Life Insurance Company)***

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

Modal Premium: $_____
One-time Enrollment Fee: $ 20
Total Premium with Application: $_____

SECTION V: 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 (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 quesion.)	☐	☐
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 the "END" date blank.) START _____ END _____		

SECTION VI: 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 and B on the effective date of the policy. If not, coverage cannot be issued.

SECTION VII: MEDICAL QUESTIONS

IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE (BASED ON YOUR ANSWERS IN SECTIONS V & VI), 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", 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 bathing, transferring, toileting, eating, or dressing?	☐	☐
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 diagnosed with a terminal illness or been hospitalized more than two (2) times, received home health care services more than three (3) times, or been confined to a nursing facility for more than thirty (30) days?	☐	☐
	b) been diagnosed with or treated (other than with maintenance medication) for angina, heart attack, atrial fibrillation, cardiomyopathy, congestive heart failure, cardiac or vascular angioplasty, stent placement, peripheral vascular disease, coronary bypass, carotid artery disease, coronary artery disease, or heart disease; had heart or heart valve surgery or required the implantation of cardiac pacemaker or defibrillator?	☐	☐
	c) 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 (other than hepatitis A), cirrhosis of the liver, or other liver disease?	☐	☐
	b) major depression, bipolar disorder, schizophrenia, or a paranoid disorder?	☐	☐
	c) diabetes requiring more than 50 units of insulin daily to control or diabetes with any of the following: neuropathy, retinopathy, vascular disease, or hypertension requiring more than two medications to control?	☐	☐
	d) chronic kidney disease, Addison's Disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant?	☐	☐
	e) internal cancer, leukemia, malignant melanoma, Hodgkin's Disease, or lymphoma?	☐	☐
	f) alcohol or drug abuse?	☐	☐
	g) paralysis, hemophilia, osteoporosis with fractures, or unrepaired aneurysm?	☐	☐
	h) Paget's Disease, rheumatoid or disabling arthritis, systemic 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) emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic Obstructive Lung Disease (COLD), or any chronic lung or respiratory disorder requiring the use of oxygen?	☐	☐
	c) amputation caused by disease or organ transplant other than corneas?	☐	☐
7)	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), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection?	☐	☐
8)	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, or any other blood disorder?	☐	☐
9)	Has surgery been advised but not performed or is any surgery anticipated, including but not limited to joint replacement or cataract surgery?	☐	☐
10)	Have medical tests (other than mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only), treatment, or therapy been advised but not performed?	☐	☐

SECTION VII: MEDICAL QUESTIONS (CONTINUED)

PART B: MEDICAL QUESTIONS - If the answer to any of the following questions is "YES", you might be eligible for coverage. Please provide complete details as requested below.

	YES	NO
11) Within the past two (2) years, have you been declined for Life, Health, or Supplemental Insurance? ..... If "YES", please provide details including the date of the declination, the type of coverage applied for, and the reason for the declination here:	☐	☐
12) In the past two (2) years, have you had PSA levels greater than 6.0 or been diagnosed with dysplasia of the cervix classified as a level 3.0 or higher? ..... If "YES", please provide details in the table below.	☐	☐
13) Within the past two (2) years, have you taken any medication for any heart or vascular disease other than hypertension? ..... If "YES" or if you are taking any medications, give complete details in Part C Medications.	☐	☐

Test	Results	Diagnosis

PART C: MEDICATIONS

14) Please list any prescription medications taken or prescribed in the past two (2) years.
If you are not taking any medications, please check here: ☐ I am not taking any medications.

Medication	Dates Taken	Condition Taken for

AGENT NOTES - Please provide any other information that you believe may assist in our underwriting determination:

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 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, the required *Guide to Health Insurance for People with Medicare*, and the MIB Notice.

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.

I ☐ ***grant*** ☐ ***do not grant*** my authorization to receive information or presentation of materials describing other insurance products.

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.

Telephone Number (_____) _____ Best time to call _____

Applicant's Printed Name _____

Signature of Applicant _____ Date _____

SECTION IX: AGENTS' 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 submitted any applications or have knowledge of any applications submitted for this Applicant that have been declined? ..... If "YES", provide details below.	☐	☐

_____

_____

4) Have you reviewed the Application for correctness and omissions?	☐	☐

5) I certify that I have provided the Applicant with the following documents:

a) Application Packet (Phone Sales only) b) *A Guide to Health Insurance for People with Medicare*
c) Outline of Medicare Supplement Coverage d) MIB Notice
e) 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 ☐ Mail _____ date

☐ Email _____ date ☐ Fax _____ date

☐ Other (explain) _____ _____ date

	YES	NO
6) Was the Application completed by you in the Applicant's physical presence?	☐	☐
7) Was the Application completed by you over the phone?	☐	☐
8) 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

Printed Name of 2nd Licensed Agent	Signature of 2nd Licensed Agent	Writing Number	Percentage

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

AMERICAN RETIREMENT LIFE INSURANCE COMPANY® • PO 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 - 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 American Retirement Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize American Retirement Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event American Retirement Life Insurance Company mistakenly deposits funds into my account, I authorize American Retirement Life Insurance to debit my account for an amount not to exceed the original amount of credit. 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 AMERICAN RETIREMENT LIFE INSURANCE COMPANY: 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 association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by American Retirement Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by American Retirement Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by American Retirement Life Insurance Company 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**

MIB, Inc., Pre-Notice

AMERICAN RETIREMENT LIFE INSURANCE COMPANY®
PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

Information regarding your insurability will be treated as confidential. American Retirement Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, 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. 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 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

American Retirement Life 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

AUTHORIZATION FORM FOR DISCLOSURE 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 American Retirement Life Insurance Company®.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., 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. However, MIB, Inc., information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB, Inc.
4. 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.
5. 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 Office at PO Box 26580, Austin, Texas 78755-0580.
6. 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.
7. 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 re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
8. 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.
9. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

_____

_____
Applicant's Name

_____
Applicant's Social Security Number

_____
Signature of Applicant **Date**

_____
Signature of Company's Agent **Date**

_____
Name of Applicant's Personal Representative, if applicable

_____
Relationship of Personal Representative to the Applicant

_____
Signature of Personal Representative **Date**

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

AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER'S PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES ("Authorization")

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company®, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization 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 Steward at PO Box 26580, Austin, Texas 78755-0580.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing 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 is 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. This Authorization will expire twenty-four (24) months from the date it is signed.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer's behalf:

_____

_____ _____

Consumer's Name **Name of Consumer's Personal Representative, if applicable**

_____ _____

Signature of Consumer **Date** **Relationship of Personal Representative to the Consumer**

_____ _____

Signature of Company's Agent **Date** **Signature of Personal Representative** **Date**

A signed copy of this form will be provided to you.

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 American Retirement Life Insurance Company (ARLIC) 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

AMERICAN RETIREMENT LIFE INSURANCE COMPANY®
PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

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 ARLIC. 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) _____

NOTE:

1) 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 note 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 **Applicant's Signature**

_____ _____

Type or Print Name and Address of Agent/Broker **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 American Retirement Life Insurance Company (ARLIC) with the application.

A copy of this form must also be left with the Applicant.

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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) _____

NOTE:

1) 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 note 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**

_____ **Applicant's Signature**

_____ **Type or Print Name and Address of Agent/Broker**

_____ **Date**

New Business Submission Form/FaxApp

To: Cigna Supplemental Benefits **Fax #: 877-704-8186**

AGENT INFORMATION *(Required)*

FROM:	
PHONE #:	**FAX #:**
WRITING #:	**EMAIL:**
DATE:	**NUMBER OF PAGES:** **+ cover**

APPLICANT INFORMATION *(Required)*

NAME:	**SS#:**	☐ **Combo** ☐ **CWA** ☐ **Draft**
NAME:	**SS#:**	☐ **Combo** ☐ **CWA** ☐ **Draft**
NAME:	**SS#:**	☐ **Combo** ☐ **CWA** ☐ **Draft**
NAME:	**SS#:**	☐ **Combo** ☐ **CWA** ☐ **Draft**
NAME:	**SS#:**	☐ **Combo** ☐ **CWA** ☐ **Draft**

All applications submitted with a single cover sheet must be from the same writing agent.

PROCEDURES

For the fastest service, send one application per cover sheet and only one application per transmission, unless sending a combo application. Check the Combo box if you are submitting multiple applications for one applicant. You may send up to five applications with a single cover sheet per transmission. **However, do not exceed 25 pages per transmission.**

Simply complete the application, and fax the following to **877-704-8186**.

- FaxApp Cover Sheet
- Application in numeric page order
- Any state-specific or replacement forms, if applicable
- **Copy of the initial premium check, if collected from the customer at the point of sale**

Medicare supplement under age 65 (disabled) cases are not eligible for the FaxApp Program. You must mail the completed application with a check for the first month's premium to the Imaging – New Business address below.

PREMIUM

- Agents are encouraged to utilize the Bank Draft Authorization form to draft for the first premium in lieu of collecting the initial premium from the applicant.
- If you collected initial premium from the applicant, **please indicate the case number on the check** and mail the check, stapled to the top of the FaxApp cover sheet, to:

Imaging – New Business
P.O. Box 559015, Austin, TX 78755-9015

We must receive the premium within 10 days of receipt of the application. If it is not received within 10 days, we will send you a letter stating that the money for the policy must be submitted immediately. If we do not receive the check after 20 days, a letter will be sent stating that the contract will be cancelled in 5 days, unless we receive payment for the issued contract. **If we do not receive payment after 25 days, a letter will be sent to you and the applicant stating that the file has been closed and the policy has been cancelled due to non-payment of premium.**

AMERICAN RETIREMENT LIFE INSURANCE COMPANY

P. O. BOX 26580 ♦ AUSTIN, TX 78755-0580 ♦ 866-459-4272

Outline of Medicare Supplement Coverage - Benefit Plans A, F, G and N

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

BASIC BENEFITS:

- Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
- Blood: First three pints of blood each year.
- Hospice: Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, Including 100% Part B Coinsurance	Basic, Including 100% Part B Coinsurance	Basic, Including 100% Part B Coinsurance	Basic, Including 100% Part B Coinsurance	Basic, Including 100% Part B Coinsurance*		Basic, Including 100% Part B Coinsurance	Hospitalization and Preventive Care Paid at 100%; Other Basic Benefits paid at 50%	Hospitalization and Preventive Care Paid at 100%; Other Basic Benefits Paid at 75%	Basic, Including 100% Part B Coinsurance	Basic, Including 100% Part B Coinsurance, Except Up to $20 Copayment for Office Visit, and up to $50 Copayment for ER Visit
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-Pocket Limit $4,940; Paid at 100% After Reached	Out-of-Pocket Limit $2,470; Paid At 100% After Reached		

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,140 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,140. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

NORTH DAKOTA

Attained Age Rates -- Effective 3/8/2013 -- Area I (580-588)

NON-TOBACCO ANNUAL & MONTHLY BANK DRAFT RATES

FEMALE RATES									MALE RATES							
Plan A		Plan F		Plan G		Plan N		Attained	Plan A		Plan F		Plan G		Plan N	
Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Age	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
1,142.38	95.16	1,407.78	117.27	1,211.41	100.91	964.69	80.36	**65**	1,313.74	109.43	1,618.94	134.86	1,393.12	116.05	1,109.40	92.41
1,142.38	95.16	1,407.78	117.27	1,211.41	100.91	964.69	80.36	**66**	1,313.74	109.43	1,618.94	134.86	1,393.12	116.05	1,109.40	92.41
1,193.80	99.44	1,469.12	122.38	1,270.36	105.82	1,009.96	84.13	**67**	1,372.87	114.36	1,689.49	140.73	1,460.92	121.69	1,161.45	96.75
1,244.63	103.68	1,527.69	127.26	1,326.65	110.51	1,053.84	87.78	**68**	1,431.31	119.23	1,756.85	146.35	1,525.65	127.09	1,211.91	100.95
1,294.54	107.84	1,587.63	132.25	1,384.25	115.31	1,097.72	91.44	**69**	1,488.73	124.01	1,825.77	152.09	1,591.88	132.60	1,262.38	105.16
1,342.88	111.86	1,643.34	136.89	1,437.77	119.77	1,139.04	94.88	**70**	1,544.31	128.64	1,889.83	157.42	1,653.43	137.73	1,309.90	109.11
1,383.02	115.21	1,697.14	141.37	1,489.47	124.07	1,180.56	98.34	**71**	1,590.46	132.49	1,951.71	162.58	1,712.89	142.68	1,357.64	113.09
1,423.15	118.55	1,750.94	145.85	1,541.17	128.38	1,222.06	101.80	**72**	1,636.62	136.33	2,013.58	167.73	1,772.35	147.64	1,405.37	117.07
1,463.29	121.89	1,804.74	150.33	1,592.88	132.69	1,263.57	105.26	**73**	1,682.79	140.18	2,075.46	172.89	1,831.81	152.59	1,453.11	121.04
1,503.43	125.24	1,858.55	154.82	1,644.58	136.99	1,305.09	108.71	**74**	1,728.95	144.02	2,137.33	178.04	1,891.27	157.54	1,500.84	125.02
1,545.11	128.71	1,914.27	159.46	1,697.98	141.44	1,347.94	112.28	**75**	1,776.88	148.01	2,201.41	183.38	1,952.68	162.66	1,550.13	129.13
1,581.08	131.70	1,971.85	164.26	1,751.91	145.93	1,393.08	116.04	**76**	1,818.25	151.46	2,267.64	188.89	2,014.69	167.82	1,602.04	133.45
1,617.62	134.75	2,030.40	169.13	1,806.74	150.50	1,438.99	119.87	**77**	1,860.26	154.96	2,334.96	194.50	2,077.75	173.08	1,654.84	137.85
1,656.36	137.97	2,092.00	174.26	1,864.34	155.30	1,487.15	123.88	**78**	1,904.82	158.67	2,405.79	200.40	2,143.99	178.59	1,710.22	142.46
1,695.76	141.26	2,154.70	179.49	1,922.99	160.19	1,536.19	127.96	**79**	1,950.13	162.45	2,477.90	206.41	2,211.44	184.21	1,766.62	147.16
1,735.83	144.59	2,218.53	184.80	1,982.70	165.16	1,586.13	132.12	**80**	1,996.21	166.28	2,551.30	212.52	2,280.10	189.93	1,824.06	151.94
1,780.84	148.34	2,297.06	191.35	2,055.61	171.23	1,648.93	137.36	**81**	2,047.97	170.60	2,641.62	220.05	2,363.96	196.92	1,896.27	157.96
1,826.68	152.16	2,377.16	198.02	2,130.00	177.43	1,713.01	142.69	**82**	2,100.69	174.99	2,733.73	227.72	2,449.50	204.04	1,969.96	164.10
1,875.22	156.21	2,461.27	205.02	2,208.05	183.93	1,780.15	148.29	**83**	2,156.51	179.64	2,830.46	235.78	2,539.27	211.52	2,047.18	170.53
1,924.71	160.33	2,547.17	212.18	2,287.77	190.57	1,848.74	154.00	**84**	2,213.42	184.38	2,929.25	244.01	2,630.94	219.16	2,126.06	177.10
1,975.17	164.53	2,634.90	219.49	2,369.20	197.35	1,918.82	159.84	**85**	2,271.45	189.21	3,030.13	252.41	2,724.57	226.96	2,206.64	183.81
2,029.09	169.02	2,727.44	227.20	2,454.38	204.45	1,991.77	165.91	**86**	2,333.45	194.38	3,136.55	261.27	2,822.54	235.12	2,290.54	190.80
2,084.31	173.62	2,822.45	235.11	2,541.87	211.74	2,066.72	172.16	**87**	2,396.95	199.67	3,245.81	270.38	2,923.14	243.50	2,376.73	197.98
2,140.85	178.33	2,920.00	243.24	2,631.71	219.22	2,143.73	178.57	**88**	2,461.98	205.08	3,358.00	279.72	3,026.46	252.10	2,465.28	205.36
2,196.59	182.98	3,017.19	251.33	2,721.28	226.68	2,220.65	184.98	**89**	2,526.08	210.42	3,469.76	289.03	3,129.46	260.68	2,553.75	212.73
2,251.40	187.54	3,113.76	259.38	2,810.37	234.10	2,297.31	191.37	**90**	2,589.11	215.67	3,580.82	298.28	3,231.92	269.22	2,641.91	220.07
2,304.70	191.98	3,212.82	267.63	2,901.44	241.69	2,376.39	197.95	**91**	2,650.41	220.78	3,694.75	307.77	3,336.66	277.94	2,732.85	227.65
2,359.01	196.51	3,313.95	276.05	2,994.42	249.44	2,457.14	204.68	**92**	2,712.86	225.98	3,811.03	317.46	3,443.59	286.85	2,825.71	235.38
2,409.57	200.72	3,410.39	284.09	3,083.22	256.83	2,534.57	211.13	**93**	2,771.01	230.83	3,921.95	326.70	3,545.71	295.36	2,914.75	242.80
2,460.96	205.00	3,508.58	292.26	3,173.62	264.36	2,613.40	217.70	**94**	2,830.10	235.75	4,034.86	336.10	3,649.65	304.02	3,005.41	250.35
2,513.18	209.35	3,608.50	300.59	3,265.62	272.03	2,693.67	224.38	**95**	2,890.16	240.75	4,149.77	345.68	3,755.46	312.83	3,097.71	258.04
2,563.45	213.54	3,680.67	306.60	3,330.93	277.47	2,747.54	228.87	**96**	2,947.97	245.57	4,232.77	352.59	3,830.57	319.09	3,159.67	263.20
2,614.72	217.81	3,754.28	312.73	3,397.55	283.02	2,802.49	233.45	**97**	3,006.92	250.48	4,317.42	359.64	3,907.19	325.47	3,222.86	268.46
2,667.02	222.16	3,829.37	318.99	3,465.50	288.68	2,858.54	238.12	**98**	3,067.06	255.49	4,403.77	366.83	3,985.33	331.98	3,287.32	273.83
2,720.36	226.61	3,905.96	325.37	3,534.82	294.45	2,915.71	242.88	**99**	3,128.41	260.60	4,491.85	374.17	4,065.04	338.62	3,353.07	279.31

Policies may be issued on an annual, semi-annual, quarterly or monthly mode.
To obtain semi-annual premiums, multiply the above-quoted annual premium by 0.52. To obtain quarterly premiums, multiply the above quoted premium by 0.265.

Add one-time enrollment fee of $20.00 to the first premium.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

NORTH DAKOTA

Attained Age Rates -- Effective 3/8/2013 -- Area I (580-588)

TOBACCO ANNUAL & MONTHLY BANK DRAFT RATES

FEMALE RATES									MALE RATES							
Plan A		Plan F		Plan G		Plan N		Attained	Plan A		Plan F		Plan G		Plan N	
Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Age	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
1,256.62	104.68	1,548.56	129.00	1,332.56	111.00	1,061.16	88.39	**65**	1,445.12	120.38	1,780.83	148.34	1,532.44	127.65	1,220.34	101.65
1,256.62	104.68	1,548.56	129.00	1,332.56	111.00	1,061.16	88.39	**66**	1,445.12	120.38	1,780.83	148.34	1,532.44	127.65	1,220.34	101.65
1,313.19	109.39	1,616.03	134.62	1,397.40	116.40	1,110.96	92.54	**67**	1,510.16	125.80	1,858.44	154.81	1,607.01	133.86	1,277.60	106.42
1,369.09	114.05	1,680.47	139.98	1,459.32	121.56	1,159.22	96.56	**68**	1,574.45	131.15	1,932.53	160.98	1,678.21	139.79	1,333.10	111.05
1,424.00	118.62	1,746.40	145.48	1,522.67	126.84	1,207.49	100.58	**69**	1,637.60	136.41	2,008.36	167.30	1,751.07	145.86	1,388.61	115.67
1,477.16	123.05	1,807.66	150.58	1,581.55	131.74	1,252.95	104.37	**70**	1,698.73	141.50	2,078.82	173.17	1,818.78	151.50	1,440.89	120.03
1,521.31	126.73	1,866.85	155.51	1,638.42	136.48	1,298.61	108.17	**71**	1,749.51	145.73	2,146.88	178.84	1,884.19	156.95	1,493.40	124.40
1,565.46	130.40	1,926.03	160.44	1,695.29	141.22	1,344.27	111.98	**72**	1,800.29	149.96	2,214.94	184.50	1,949.58	162.40	1,545.91	128.77
1,609.62	134.08	1,985.22	165.37	1,752.17	145.96	1,389.93	115.78	**73**	1,851.06	154.19	2,283.00	190.17	2,014.99	167.85	1,598.42	133.15
1,653.77	137.76	2,044.40	170.30	1,809.04	150.69	1,435.59	119.58	**74**	1,901.84	158.42	2,351.07	195.84	2,080.40	173.30	1,650.93	137.52
1,699.62	141.58	2,105.70	175.40	1,867.77	155.59	1,482.73	123.51	**75**	1,954.57	162.82	2,421.55	201.72	2,147.95	178.92	1,705.14	142.04
1,739.19	144.87	2,169.04	180.68	1,927.10	160.53	1,532.39	127.65	**76**	2,000.07	166.61	2,494.39	207.78	2,216.16	184.61	1,762.25	146.80
1,779.38	148.22	2,233.44	186.05	1,987.41	165.55	1,582.88	131.85	**77**	2,046.28	170.46	2,568.46	213.95	2,285.52	190.38	1,820.32	151.63
1,822.00	151.77	2,301.20	191.69	2,050.77	170.83	1,635.87	136.27	**78**	2,095.30	174.54	2,646.37	220.44	2,358.39	196.45	1,881.24	156.71
1,865.34	155.38	2,370.17	197.44	2,115.29	176.20	1,689.81	140.76	**79**	2,145.15	178.69	2,725.70	227.05	2,432.58	202.63	1,943.28	161.88
1,909.42	159.05	2,440.38	203.28	2,180.97	181.67	1,744.75	145.34	**80**	2,195.83	182.91	2,806.44	233.78	2,508.11	208.93	2,006.46	167.14
1,958.93	163.18	2,526.76	210.48	2,261.18	188.36	1,813.83	151.09	**81**	2,252.77	187.66	2,905.78	242.05	2,600.36	216.61	2,085.91	173.76
2,009.36	167.38	2,614.87	217.82	2,343.01	195.17	1,884.31	156.96	**82**	2,310.76	192.49	3,007.10	250.49	2,694.45	224.45	2,166.96	180.51
2,062.74	171.83	2,707.40	225.53	2,428.86	202.32	1,958.17	163.12	**83**	2,372.16	197.60	3,113.51	259.36	2,793.18	232.67	2,251.89	187.58
2,117.19	176.36	2,801.89	233.40	2,516.55	209.63	2,033.62	169.40	**84**	2,434.77	202.82	3,222.18	268.41	2,894.03	241.07	2,338.66	194.81
2,172.69	180.99	2,898.39	241.44	2,606.12	217.09	2,110.70	175.82	**85**	2,498.59	208.13	3,333.14	277.65	2,997.04	249.65	2,427.31	202.19
2,232.00	185.93	3,000.18	249.91	2,699.82	224.90	2,190.95	182.51	**86**	2,566.79	213.81	3,450.20	287.40	3,104.80	258.63	2,519.58	209.88
2,292.74	190.99	3,104.69	258.62	2,796.05	232.91	2,273.40	189.37	**87**	2,636.64	219.63	3,570.40	297.41	3,215.46	267.85	2,614.40	217.78
2,354.94	196.17	3,212.00	267.56	2,894.88	241.14	2,358.10	196.43	**88**	2,708.17	225.59	3,693.80	307.69	3,329.11	277.31	2,711.82	225.89
2,416.26	201.27	3,318.90	276.46	2,993.40	249.35	2,442.72	203.48	**89**	2,778.69	231.46	3,816.74	317.93	3,442.41	286.75	2,809.13	234.00
2,476.55	206.30	3,425.14	285.31	3,091.40	257.51	2,527.04	210.50	**90**	2,848.03	237.24	3,938.91	328.11	3,555.12	296.14	2,906.10	242.08
2,535.17	211.18	3,534.11	294.39	3,191.59	265.86	2,614.03	217.75	**91**	2,915.45	242.86	4,064.22	338.55	3,670.33	305.74	3,006.14	250.41
2,594.91	216.16	3,645.34	303.66	3,293.86	274.38	2,702.85	225.15	**92**	2,984.15	248.58	4,192.14	349.21	3,787.94	315.54	3,108.28	258.92
2,650.53	220.79	3,751.44	312.49	3,391.55	282.52	2,788.02	232.24	**93**	3,048.11	253.91	4,314.15	359.37	3,900.27	324.89	3,206.23	267.08
2,707.06	225.50	3,859.43	321.49	3,490.97	290.80	2,874.74	239.47	**94**	3,113.12	259.32	4,438.34	369.71	4,014.62	334.42	3,305.95	275.39
2,764.51	230.28	3,969.35	330.65	3,592.18	299.23	2,963.03	246.82	**95**	3,179.18	264.83	4,564.75	380.24	4,131.01	344.11	3,407.49	283.84
2,819.80	234.89	4,048.73	337.26	3,664.03	305.21	3,022.30	251.76	**96**	3,242.77	270.12	4,656.04	387.85	4,213.63	351.00	3,475.64	289.52
2,876.20	239.59	4,129.71	344.00	3,737.30	311.32	3,082.74	256.79	**97**	3,307.62	275.52	4,749.17	395.61	4,297.91	358.02	3,545.16	295.31
2,933.72	244.38	4,212.30	350.88	3,812.05	317.54	3,144.39	261.93	**98**	3,373.78	281.04	4,844.15	403.52	4,383.86	365.18	3,616.05	301.22
2,992.39	249.27	4,296.55	357.90	3,888.29	323.89	3,207.29	267.17	**99**	3,441.25	286.66	4,941.03	411.59	4,471.54	372.48	3,688.38	307.24

Policies may be issued on an annual, semi-annual, quarterly or monthly mode.
To obtain semi-annual premiums, multiply the above-quoted annual premium by 0.52. To obtain quarterly premiums, multiply the above quoted premium by 0.265.

Add one-time enrollment fee of $20.00 to the first premium.

Locate appropriate Area according to the applicant's ZIP Code in the ZIP Code chart below.

NORTH DAKOTA ZIP CODES:

Area	**3-Digit ZIP Codes**
Area I	580-588

PREMIUM INFORMATION

Your premium will increase each year because of the increase in your attained age. We, American Retirement Life Insurance Company, can also raise your premium if (a) we change the rates which apply to all policies of this form issued by us and in-force in your state; (b) coverage under Medicare changes; or (c) you move to a different ZIP Code location. We will send you a written notice at least thirty (30) days in advance when we change the premium rates for all policies of this form issued by us and in-force in your state.

There will be a one-time enrollment fee of $20 added to the first premium.

DISCLOSURES

Use this Outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an Outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and American Retirement Life Insurance Company.

30-DAY RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to American Retirement Life Insurance Company, P. O. Box 26580, Austin, TX 78755-0580. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of your premiums.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither American Retirement Life Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. We may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

RENEWABILITY

This policy is guaranteed renewable for life.

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,216	$0	$1,216 (Part A Deductible)
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $608 a day	$608 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $152 a day	$0	Up to $152 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

***** Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
(Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES –			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,216	$1,216 (Part A Deductible)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $608 a day	$608 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $152 a day	Up to $152 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

***** Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$147 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
(Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$147 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES –			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$147 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONTINUED)

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,216	$1,216 (Part A Deductible)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $608 a day	$608 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $152 a day	Up to $152 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

***** Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
(Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES –			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONTINUED)

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,216	$1,216 (Part A Deductible)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $608 a day	$608 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $152 a day	Up to $152 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

***** Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense
PART B EXCESS CHARGES (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONTINUED)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 Each Calendar Year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum