ACE PROPERTY & CASUALTY INSURANCE COMPANY

Home Office: Philadelphia, Pennsylvania
Administration: P.O. Box 10856, Clearwater, Florida 33757-8856

APPLICATION FOR MEDICARE SUPPLEMENT COVERAGE

SECTION A. PROPOSED INSURED INFORMATION

Applicant Name *(exactly as it appears on your Medicare card)*	
Resident Address	Phone *(with area code)*
City	State, Zip Code
Date of Birth	Age
Male ☐ Female ☐	Social Security No
Medicare Number	
Email Address	

SECTION B. PLAN AND PREMIUM INFORMATION

Plan*	Requested Policy Effective Date
*Plan F is only available to individuals who were eligible for Medicare prior to January 1, 2020.	
Household Premium Discount ☐ No ☐ Yes (please complete the Household Discount Form)	
Premium $	Policy Fee $
Premium Collected** $	Initial Bank Draft: $
**Only one month's premium is allowed to be collected at the time of application.	

Payment Mode: Bank Draft ☐ Monthly ☐ (Bank Draft ONLY) Annual ☐ Semi-Annual ☐ Quarterly ☐

SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

1. Are you covered under Medicare Part A?	Yes ☐ No ☐
If NO, what is your future Part A effective date? _____	
If YES, what is your Part A effective date? _____	
2. Are you covered under Medicare Part B?	Yes ☐ No ☐
If NO, what is your future Part B effective date? _____	
If YES, what is your Part B effective date? _____	
Have you enrolled in Medicare Part B more than once?	Yes ☐ No ☐
3. Are you applying during a guaranteed issue period? (If YES please provide proof of eligibility).	Yes ☐ No ☐
4. Are you eligible for Medicare due to Disability or End Stage Renal Disease (ESRD)?	Yes ☐ No ☐
(If YES please check the box that applies. Disability ☐ End Stage Renal Disease (ESRD) ☐	

SECTION D. HEALTH QUESTIONS

If applying during your Open Enrollment period or qualify for Guaranteed Issue, SKIP THIS SECTION and go to SECTION F. Refer to SECTION G for assistance in determining if you qualify for either Open Enrollment or Guaranteed Issue.

If you do not qualify for Open Enrollment or Guaranteed Issue, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. For questions 2-21, please answer with Yes (Y), No (N), or Not Sure (NS). If you answer YES to any of the following questions 3–17, you are not eligible for coverage.

1. Height *Feet and inches*_____ Weight *Pounds*_____

2. Have you used tobacco in any form, including cigarettes, vapes, nicotine gum or patches, cigars, chewing tobacco, pipes, or eCigarettes in the past twelve (12) months? Y ☐ N ☐ NS ☐

3. Are you currently hospitalized or in a nursing home or assisted living facility; or, are you bedridden or confined to a wheelchair, or require the assistance of motorized mobility aid, or have you had any amputation caused by disease? Y ☐ N ☐ NS ☐

4. Are you currently receiving any occupational, speech, or physical therapy, or are you currently receiving any services from a home healthcare agency? Y ☐ N ☐ NS ☐

5. Have you had, been medically diagnosed with, or treated at any time for Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any other chronic pulmonary disorders, or any medical condition requiring the use of oxygen? Y ☐ N ☐ NS ☐

6. Have you had, been medically diagnosed with, or treated at any time for Parkinson's Disease, Arthritis that restricts mobility, Systemic Lupus, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Scleroderma, Chronic kidney disease (stage 3-5), Chronic Hepatitis, Cirrhosis of the liver, or renal failure requiring dialysis? Y ☐ N ☐ NS ☐

7. Have you been diagnosed with Alzheimer's Disease, Dementia, Muscular Dystrophy, or any other cognitive disorder? Y ☐ N ☐ NS ☐

8. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.** Y ☐ N ☐ NS ☐

9. If you have diabetes or take prescription medication to control your blood sugar, have you been medically diagnosed with or treated for any of the following conditions: peripheral vascular disease, peripheral venous thrombotic disease, peripheral artery disease, kidney failure, kidney disease, stroke, transient ischemic attack (TIA), congestive heart failure, or any heart disorder? If you do **not** have diabetes or do not take prescription medication to control your blood sugar, this question should be answered "NO." Y ☐ N ☐ NS ☐

10. If you have diabetes or take prescription medication to control your blood sugar, do you take three (3) or more medications (oral or injections) to control your blood sugar? If you do **not** have diabetes or do not take prescription medication to control your blood sugar, this question should be answered "NO." Y ☐ N ☐ NS ☐

SECTION D. HEALTH QUESTIONS (continued)

11. If you have diabetes or take prescription medication to control your blood sugar, do you take four (4) or more medications to control your high blood pressure? If you do **not** have diabetes or do not take prescription medication to control your blood sugar, this question should be answered "NO." Y ☐ N ☐ NS ☐

12. Have you ever had a medical professional advise you to take more than 50 units of insulin daily or have you ever required more than 50 units of insulin daily for diabetes or to control your blood sugar? Y ☐ N ☐ NS ☐

13. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for internal cancer (examples include but are not limited to liver, breast or lung cancer, etc.), malignant melanoma, lymphoma, leukemia, Hodgkin's disease, alcoholism or drug abuse, or have you been advised to have a joint replacement? Y ☐ N ☐ NS ☐

14. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for heart attack, cardiac angioplasty, implantation of a pacemaker, bypass surgery, stent placement or replacement, vascular angioplasty, endarterectomy, stroke or transient ischemic attack (TIA)? Y ☐ N ☐ NS ☐

15. Have you been advised by a physician to have surgery (including cataract or joint replacement surgery), medical tests, infusions, treatment or therapy that has not been performed? Y ☐ N ☐ NS ☐

16. Have you been hospital confined three (3) or more times in the last two (2) years? Y ☐ N ☐ NS ☐

17. Have you had, been medically diagnosed with, or treated at any time for an organ transplant, been advised by a physician to have an organ transplant (excluding cornea transplants) or had a cardiac defibrillator implanted? Y ☐ N ☐ NS ☐

If you answer YES to any of the following health questions 18-21, you may be eligible for coverage.

18. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for angina, heart attack, heart disease, heart valve disease, coronary artery disease, aortic or cardiac aneurysm, cardiomyopathy, carotid artery disease (not including high blood pressure), congestive heart failure, atrial fibrillation, peripheral vascular disease, peripheral venous thrombotic disease, enlarged heart, or other heart rhythm disorder? Y ☐ N ☐ NS ☐

19. Within the past two (2) years have you been treated for degenerative bone disease, rheumatoid arthritis, or spinal stenosis? Y ☐ N ☐ NS ☐

20. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for a mental or nervous disorder requiring treatment by a psychiatrist? Y ☐ N ☐ NS ☐

21. Are you currently receiving, or have you been advised to receive injections in a physician's office? Y ☐ N ☐ NS ☐

SECTION D. HEALTH QUESTIONS (continued)
(Please explain any yes answers to questions 18 – 21 below)

SECTION E. MEDICATION HISTORY

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes ☐ No ☐

If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Date prescription last filled	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Date prescription last filled	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Date prescription last filled	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Date prescription last filled	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Date prescription last filled	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Date prescription last filled	
Dosage and Frequency	
Diagnosis/Condition	

SECTION F. REPLACEMENT QUESTIONS

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

To the Best of Your Knowledge:

1. (a) Did you turn 65 years of age in the last six months? Yes ☐ No ☐

   (b) Did you enroll in Medicare Part B in the last six months? Yes ☐ No ☐

   (c) If YES, what is your effective date? / /

2. Are you covered for medical assistance through California's Medi-Cal program? Yes ☐ No ☐

   (NOTE TO APPLICANT: If you have share of cost under the Medi-Cal program, please answer NO to the above question.)
   If YES, answer (a) – (b) below.

   (a) Will Medi-Cal pay your premiums for this Medicare supplement policy? Yes ☐ No ☐

   (b) Do you receive any benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium? Yes ☐ No ☐

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.) Yes ☐ No ☐

   If YES, answer (a) – (d) below.

   (a) Name of Company

   Plan Type & Policy/Certificate No

   Company Telephone Number

   Coverage Dates: START DATE / /

   (if you are still covered under this plan, leave end date blank) END DATE / /

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes ☐ No ☐

   (c) Was this your first time in this type of Medicare plan? Yes ☐ No ☐

   (d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes ☐ No ☐

4. Do you have another Medicare supplement policy in force? Yes ☐ No ☐

   If YES, answer (a) and (b) below.

   (a) Name of Company

   Plan Type & Policy/Certificate No

   Company Telephone Number

   Issue Date / /

   (b) Do you intend to replace your current Medicare supplement policy with this policy? Yes ☐ No ☐

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) Yes ☐ No ☐

   If YES, answer below.

   Name of Company

   Plan Type & Policy/Certificate No

   Company Telephone Number

   Coverage Dates: START DATE / /

   (if you are still covered under this plan, leave end date blank) END DATE / /

SECTION G. OPEN ENROLLMENT AND GUARANTEED ISSUE ELIGIBILITY

If You are eligible for Open Enrollment or Guaranteed Issue, you will not need to answer Sections D and E on pages 2 through 5 of this application.

Open Enrollment: The following are the requirements of individuals who are eligible for Open Enrollment:

a. A policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

b. An issuer shall make available Medicare supplement benefit plans A, B, D and G if currently available to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

c. An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment for six months after the date of enrollment in Medicare Part B, or if notified retroactively of eligibility for Medicare, for six months following notice of eligibility.

d. An individual enrolled in Medicare Part B is entitled to open enrollment for six months following receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer sponsored health plan including an employer-sponsored retiree health plan, receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan, or termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

e. An individual enrolled in Medicare Part B is entitled to open enrollment if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan.

f. An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by a Medicare supplement issuers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.

g. An individual shall be entitled to an annual open enrollment period lasting 60 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy, that offers benefits equal to or lesser than those provided by the previous coverage.

h. An individual enrolled in Medicare Part B is entitled to open enrollment upon being notified that, because of an increase in the individual's income or assets, they meet one of the following requirements: (1) they are no longer eligible for Medi-Cal benefits or (2) they are only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that they have not met the share of cost.

SECTION G. OPEN ENROLLMENT AND GUARANTEED ISSUE ELIGIBILITY (continued)

Guaranteed Issue For Eligible Persons: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue:

a. Enrolled under an employee welfare benefit plan that provides health benefits under Medicare and either of the following applies: (1) the plan either terminates or ceases to provide all of those supplemental health benefits to the individual; or (2) the employer no longer provides the individual with insurance that covers all of the payment of the 20% coinsurance; or

b. Enrolled in a Medicare Advantage plan, Program of All-Inclusive Care for the Elderly (PACE), or any similar organization operating under demonstration project authority and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated for all individuals within a residence area, the organization substantially violated a material policy provision, a material misrepresentation was made to the individual, the organization, or agent, or other entity acting on the organizations behalf materially misrepresented the plan's provisions in marketing the plan to the individual, or the individual meets other exceptional conditions as the Secretary may provide; or

c. Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and premiums or copayments increase by 15% or more, benefits are reduced, or the provider contract is terminated with the medical provider treating the individual; or

d. Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated for all individuals within a residence area, the organization, or agent, or other entity acting on the organization's behalf substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

e. Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, bankruptcy or other involuntary termination of coverage or enrollment under the policy, substantial violation of a material policy provision, or material misrepresentation; or

f. Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment; or

g. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy; or

h. Upon first becoming enrolled for benefits under Medicare Part A at age 65, enrolled in a Medicare Advantage plan under Medicare Part C or Medicare, or with a PACE provider under Section 1894 of the federal Social Security Act, and then disenrolls from the plan or program not later than twelve (12) months after the effective date of enrollment.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement Insurance Policy.
- If, after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy will be reinstituted, if requested, within 90 days of losing Medi-Cal eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services are available in this state to provide advice concerning your purchase of a Medicare supplement insurance and concerning medical assistance through the state Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance’s toll-free telephone number 1-800-927-HELP, or access the Department of Insurance’s internet website, www.insurance.ca.gov, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.
- A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's internet website (www.insurance.ca.gov).

ELECTRONIC INSTRUCTIONS

Authorization is requested by ACE Property & Casualty Insurance Company to act on electronic instructions from the applicant, and to electronically deliver statements and other documents to the applicant. Proper identification must be provided. The Company will be held harmless for any claim, liability, loss or cost, when it has used reasonable procedures to confirm these transactions are authorized and genuine, and these procedures have been followed.

(Check One)

☐ I authorize ACE Property & Casualty Insurance Company to act on electronic instructions, and to electronically deliver statements and other documents for the purposes of accepting electronic delivery of the documents and a means by which I can provide a current Internet email address. I acknowledge that should I desire to revoke this written authorization, I will inform the Company in writing, of such revocation.

☐ I DO NOT authorize ACE Property & Casualty Insurance Company to act on electronic instructions, and to electronically deliver statements and other documents.

Note: I acknowledge that I am responsible for notifying ACE Property & Casualty Insurance Company in the event that the email address should change and that I have the option to receive written communication in paper form.

AUTHORIZATION AND CERTIFICATION

It is very important that you review your application carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (“my providers”) to disclose my entire medical record, prescription history, medications prescribed and any other health information concerning me (“protected health information”) to the Company. I also authorize any insurance company or agent from which I have applied for or obtained insurance, any consumer reporting agency such as MIB, LLC, and any other entity or person having protected health information about me, to disclose it to the Company. Protected health information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Protected health information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

Further, protected health information includes genetic information and genetic test results, and I specifically authorize my providers to disclose such information and results to the Company, subject to the terms and conditions of this authorization.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my providers and other entities or persons referred to above to release and disclose my entire medical record without restriction.

I further authorize the disclosure of protected health information by the Company to its affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency such as MIB, LLC.

I understand that this protected health information is to be used or disclosed under this authorization so that the Company may: 1) underwrite my application for insurance, make eligibility, risk rating, and policy issuance determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

AUTHORIZATION AND CERTIFICATION (continued)

This authorization shall remain in force for 12 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Company at their Medicare Supplement Administrative Office: P.O. Box 10856, Clearwater, Florida 33757-8856. I understand that a revocation is not effective to the extent that any person or entity has already relied on this authorization to disclose or use information about me or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that if any of my protected health information is re-disclosed, it may no longer be protected by federal rules governing privacy and confidentiality of health information.

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand and acknowledge that I or any authorized representative will receive or have received a copy of this authorization and that I have the right to a copy of this authorization, at any time, by sending a written request to the Company at their Medicare Supplement Administrative Office: P.O. Box 10856, Clearwater, Florida 33757-8856. A photocopy of this authorization will be treated in the same manner as the original.

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I wish to apply for a Medicare supplement insurance policy. To the best of my knowledge and belief, all answers contained in this application are accurate and complete. I acknowledge that I have received or been given access to review or print: (a) an Outline of Coverage for the policy applied for, and (b) a "*Guide to Health Insurance for People with Medicare*."

Signed at: _____ _____ _____

State | Applicant's Signature | Signature Date

This section to be completed only by an agent, if applicable.

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

(1) List policies sold which are still in force.

Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

(2) List policies sold in the past five (5) years which are no longer in force.

Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

AGENT CERTIFICATION

I, the authorized agent, have on the date of application recorded the information as given to me by the Applicant, and certify that during an interview with the proposed applicant, I have truly and accurately recorded in the application the information supplied by the applicant.

The application was provided to the applicant to review and the applicant has been advised that any false statements or misrepresentations in this application may result in loss of coverage under the policy.

I understand that if I, as an agent, state any material fact that I know to be false, I am subject to a civil penalty of up to ten thousand dollars ($10,000).

Signed at:

State	Signature of Agent	Writing Number	Signature Date

Policy Mailing Preference: ☐ Mail to Insured ☐ Mail to Licensed Agent