

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE
For Seniors with Medicare Parts A and B



SECTION 1 – APPLICATION INFORMATION

A copy of this application will be returned to you, for your records, along with your policy, when you are enrolled.

Please copy the information from your Medicare card here



NAME OF BENEFICIARY (Applicant)	CLAIM NUMBER	SEX
IS ENTITLED TO	EFFECTIVE DATE	
HOSPITAL INSURANCE (PART A)		
MEDICAL INSURANCE (PART B)		

Requested effective date ____ / ____ / ____

Have you used any form of tobacco in the past 5 years? ☐ Yes ☐ No Height ____ Weight ____
(Questions regarding tobacco use and ht/wt need not be answered during open enrollment and guaranteed issue periods.)

Name (as it appears on your Medicare card) _____

Social Security Number

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 Date of Birth _____

Home Address, Apt. No., Suite No. _____

City _____ County _____ State _____ Zip _____

Home Telephone Number _____

Billing Address (if different from home address) _____

City _____ County _____ State _____ Zip _____

Care of/Attention _____

SECTION 2 – CHOICE OF COVERAGE

Newly Eligible Applicant Medicare Supplement Standard Plans: <input type="checkbox"/> A <input type="checkbox"/> G <input type="checkbox"/> G (High Deductible) <input type="checkbox"/> M <input type="checkbox"/> N	Applicant (other than Newly Eligible Applicant) Medicare Supplement Standard Plans: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> F (High Deductible) <input type="checkbox"/> G <input type="checkbox"/> G (High Deductible) <input type="checkbox"/> M <input type="checkbox"/> N
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Newly Eligible Applicant means those persons who a) attain the age of 65 on or after January 1, 2020 or b) first become eligible for Medicare due to age, disability or end-stage renal disease, on or after January 1, 2020.

SECTION 3 – BILLING INFORMATION

- ☐ **Automatic Deduction from Checking or Savings Account** ☐ **Direct Bill** (Monthly not available) ☐ **Credit Card**
Draft upon (choose one) ☐ Approval of Application ☐ Policy Effective Date
☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Please make check or money order for premium payable to Philadelphia American Life Insurance Company.

No agency checks are accepted.

Applicant: Please return application to agent or to the address below:

Philadelphia American Life Insurance Company, Underwriting Department
P.O. Box 4884 Houston, Texas 77210-4884

SECTION 4 – HEALTH HISTORY

THIS SECTION MUST BE COMPLETED BY APPLICANT

IF APPLYING DURING THE OPEN ENROLLMENT PERIOD OR IF YOU ARE A GUARANTEED ISSUE ELIGIBLE PERSON, DO NOT COMPLETE THIS SECTION (Skip to Section 6)

If the answer to questions 1 through 7 is “Yes”, you will not be eligible for coverage.

Check the box next to any conditions that apply to you.

	Yes	No
1. Are you currently confined, or has confinement been recommended to a bed, hospital, nursing facility, or other care facility, or are you currently undergoing physical therapy?	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for a total of 2 weeks or longer?	<input type="checkbox"/>	<input type="checkbox"/>
3. Within the past 2 years, have you been advised to have surgery (including a biopsy), therapy, diagnostic testing, or any treatment which has not yet been done?	<input type="checkbox"/>	<input type="checkbox"/>
4. Within the past 5 years, have you consulted a medical professional, sought treatment, had treatment recommended, received treatment (including injection therapy), been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for the following conditions:		
a. Heart or vascular conditions including but not limited to heart attack, open heart surgery, placement of a stent or defibrillator, heart valve replacement, angioplasty, any aneurysm, congestive heart failure, enlarged heart, peripheral vascular disease, coronary artery disease, irregular heartbeat, stroke, (TIA) transient ischemic attack or blood transfusion therapy?	<input type="checkbox"/>	<input type="checkbox"/>
b. Alzheimer's disease, Parkinson's disease, Lou Gehrig's Disease (ALS), senile dementia or other senility disorder, organic brain disorder, any neurological disorder including spinal stenosis, any autoimmune disorder (including but not limited to Lupus, Rheumatoid arthritis, Multiple Sclerosis and Myasthenia Gravis)?	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic Obstructive Pulmonary Disease (COPD), asbestosis, or emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
d. Internal cancer, Leukemia, melanoma, Hodgkin's disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), chronic kidney disease stages 3, 4 or 5, kidney/renal failure, dialysis, cirrhosis of the liver, chronic hepatitis B or C, organ transplant (except cornea), or amputation?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have diabetes:		
a. With complications including, retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage?	<input type="checkbox"/>	<input type="checkbox"/>
b. Treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>
c. With uncontrolled high blood pressure in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
d. With the use of insulin in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
6. In the past 12 months have you had placement of a pacemaker or had a joint replacement?	<input type="checkbox"/>	<input type="checkbox"/>
7. Within the past 2 years, have you been confined in a facility for drug or alcohol abuse or a mental/nervous condition?	<input type="checkbox"/>	<input type="checkbox"/>
8. In the past 2 years have you been treated for asthma, allergies, (or any chronic pulmonary condition not listed in Question 4c) with the use of inhalers, nebulizer or oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you been treated for degenerative disc disease in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you need the assistance of a wheelchair, cane, or walker for mobility purposes?	<input type="checkbox"/>	<input type="checkbox"/>

Please provide a list of any medications taken or prescribed to you in the past 5 years:

SECTION 5 – MEDICAL INFORMATION

Name of Primary Care Physician _____ Telephone (_____) _____

Address _____

SECTION 6 – GENERAL INFORMATION

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,

Did you turn age 65 in the last 6 months? ☐ Yes ☐ No

Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No

If yes, what is the effective date? _____

Are you covered for medical assistance through the state Medicaid program? {NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.}

☐ Yes ☐ No

If yes; will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No

Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No

If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START ____/____/____ END ____/____/____

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

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

Did you drop a Medicare supplement policy to enroll in this Medicare plan? ☐ Yes ☐ No

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

If so, with what company, and what plan do you have? _____

If so, do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

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 so, with what company and what kind of policy? _____

What are your dates of coverage under the other policy? START ____/____/____ END ____/____/____ (If you are still covered under the other policy, leave "END" blank.)

SECTION 7 – CONDITIONS OF APPLICATION

Please read the following carefully.

1. I agree to submit the premium required for the plan requested with this application. Such premium will be returned to me if my application is rejected or if I decide to cancel the policy within the first thirty (30) days. If my application is accepted, the amount paid will be applied to the premium.
2. Philadelphia American Life Insurance Company (Philadelphia American) will not reject my application if it is submitted during the six-month period beginning in the first month after I first enrolled in Medicare Part B or when I am an Eligible Person for Guaranteed Issue. If my application is not received during the open enrollment period, Philadelphia American has the right to reject my application. If Philadelphia American rejects my application, I will be notified in writing and the premium submitted with this application will be refunded. I understand and agree that if Philadelphia American rejects my application, under no circumstances will any Philadelphia American benefits be payable. **Cashing of my check by Philadelphia American does not constitute approval of my application.**
3. If my application is accepted, this application will become part of the agreement between Philadelphia American and myself.
4. The selling agent has no authority to promise me coverage or to modify Philadelphia American underwriting policy or terms of any Philadelphia American coverage.
5. I alone am responsible for reading and accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, **even information about my Medicare coverage**, is false, incomplete or omitted and that Philadelphia American may void all coverage from the original effective date of the policy for material misstatements or omissions.

SECTION 8 – AUTHORIZATION AND AGREEMENTS

Notice to Applicant

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

Authorization To Obtain or Release Medical Information – You Are Entitled To A Copy of This Signed Authorization for Your Files If Requested. (Read all paragraphs and sign below.)

- I hereby authorize the U.S. Department of Health and Human Services (including the Health Care Financing Administration and any contractors or agents, including Medicare intermediaries), any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of Philadelphia American Life Insurance Company (Philadelphia American) any and all records pertaining to claims payments or rejections, medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or a claim.
- I also authorize Philadelphia American or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such a disclosure is necessary to allow the processing of any claim.
- This authorization shall become effective after the date this application is signed and shall remain in effect for 24 months. A photocopy shall be valid.
- I understand that I may revoke this authorization in writing at any time (except to the extent that action has already been taken by Philadelphia American in reliance on this authorization) by sending a written revocation to Philadelphia American Life Insurance Company, P.O. Box 4884, Houston, TX. 77210-4884.
- I understand and agree to the Conditions of Application and the Authorization. I acknowledge receipt of the “Guide to Health Insurance for People with Medicare,” “Outline of Coverage and Premium Information” as required as well as the Notice To Applicant Regarding Replacement if this is a replacement. I understand that receipt of money with this application does not create Philadelphia American coverage. Coverage will come into effect only if this application is approved by Philadelphia American.
- I, the applicant, acknowledge that I have read and understand this Application in its entirety and realize that any false statement or intentional material misrepresentation in the Application may result in loss of coverage under the policy.

No insurer shall, on the basis of any genetic information concerning you or on the basis of your request for or receipt of genetic services, or the refusal to submit to a genetic test or make available the results of a genetic test; terminate, restrict, limit, cancel, refuse to renew, deny coverage, impose a rider that excludes coverage, maintain different rates or cost sharing or otherwise apply conditions to insurance coverage. No insurer shall require you be a subject of a genetic test or to be subjected to questions relating to genetic information.

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 is guilty of a crime and may be subject to fines and confinement in prison.

X

Applicant's Signature

Date of Signature

ELECTRONIC CONSENT AUTHORIZATION

I consent to electronic communication with Philadelphia American Life Insurance Company using the email address provided below. I understand that I can withdraw consent or update my email address at any time by contacting the Company. Electronic communication means informational emails, notices and documents regarding your application and insurance coverage. I understand that a failure to receive such communication due to an incorrect email address is no fault of the Company. If the Company has reason to believe that you have not received Company communications, the Company will deliver all future communication by first-class mail.

Email Address _____

Signature _____

Date _____

AUTOMATIC ACCOUNT DEDUCTION AUTHORIZATION

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Philadelphia American Life Insurance Company (Philadelphia American) provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize Philadelphia American to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Philadelphia American premiums. This authority is to 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 debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no obligation whatsoever even though such dishonor results in forfeiture of insurance.

This form must be completed to have premiums automatically deducted from your bank account.

Account Holder's First Name: _____

Account Holder's Last Name: _____

Name of Bank: _____

Routing Number: _____

Account Number: _____

Type of Account: ☐ Checking ☐ Savings

Preferred Draft Date (excluding the 29th, 30th, 31st): _____

Draft date will be the same day as the effective date's day unless a preferred date is indicated.

Signature: _____ Date: ____ / ____ / ____

Signature as it appears in the financial institution's records for the account to which this authorization is applicable.

For paper applications only, please attach a blank check marked "VOID". A deposit slip is not acceptable. Please refer to Check Sample below to locate your Routing Number and Account Number.

Check Sample

The diagram shows a sample check with the following fields and annotations:

- Top Left:** John Doe, 123 W. Main St., Anytown, USA 12345
- Top Right:** DATE _____
- Bottom Right:** 101 (Check Number)
- Payable To:** PAY TO THE ORDER OF _____ \$ _____ DOLLARS
- Bank Name:** YOUR BANK, ANYTOWN, USA
- FOR:** _____
- Routing Number:** 101010011 (An arrow points from the label "Bank Routing Number" to this field)
- Account Number:** 05510051151 (An arrow points from the label "Bank Account Number" to this field)
- Check Number:** 101 (An arrow points from the label "Do not include Check Number on form." to this field)

FOR AGENT ONLY

Please list any other health insurance policies or coverages you have sold to the applicant which are still in force, and any other health insurance policies or coverages you have sold to the applicant in the past five years which are no longer in force. Please submit with the application, as required:

Date	Name/Type of Policy	Name and Address of Insurance Company
From: Mo./Yr. _____	_____	Name: _____
To: Mo./Yr. _____	_____	Address: _____
	_____	City/State: _____

(Attach additional sheets if necessary)

I have read and understand the application. I additionally certify that I have given the "Guide to Health Insurance for People with Medicare" and an Outline of Coverage and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage.

SIGNED AT

Writing Agent's Signature _____ Date of Signature _____ (City and State) _____

Print Writing Agent's Name _____ Writing Agent No. _____

Street Address _____ Telephone No. _____

City _____ State _____ ZIP _____

E-mail Address _____ *For split commissions, please add name and agent no.*

Premium Amount \$ _____
 2nd Agent Name _____

Send Policy To: ☐ Agent ☐ Insured
 2nd Agent No. _____

SENIOR SERVICES TOLL-FREE NUMBER

Monday - Friday: 8:00 a.m. to 5:00 p.m. (Central Standard Time)

(877) 417-7555

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

PREMIUM RECEIPT

Date _____ Amount _____

Name _____

Social Security Number _____

Account _____ Check Number _____

Policy Description _____

Received by _____

This is a receipt for cash received only. This receipt does not guarantee insurance coverage.



P.O. Box 4884, Houston, TX 77210-4884

SPOUSAL COVERAGE DISCOUNT FORM
MEDICARE SUPPLEMENT PLANS

1) APPLICANT/INSURED

Insured/Applicant Name: _____
Last/First/MI

Date of Application: _____

Policy Number if Applicable: _____

Social Security Number: _____

2) APPLICANT

Applicant Name: _____
Last/First/MI

Date of Application: _____

Social Security Number: _____



P.O. Box 4884 • Houston, Texas 77210 • (800) 713-4680

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

Applicant / Primary Insured Name

Policy / Certificate # (if applicable)

Phone #

Address (Street, City, State, Zip)

Protected Health Information (PHI) to be Used and/or Disclosed: Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-related complex).

Entities or Persons Authorized to Use or Disclose: U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist, Pharmacy Benefit Manager or any other medical or medically related facility or professional.

Entities or Persons Authorized to Receive: Philadelphia American Life Insurance Company (PALIC) or its agents, employees, designees, or representatives, including my PALIC agent or broker.

Purpose of this Authorization: By signing this form, you will authorize PALIC to use and/or disclose your Protected Health Information (PHI) to determine if your application will be approved for health insurance or that you are eligible for benefits. This authorization is a condition of your approved application for our health insurance or your eligibility for benefits.

You also will authorize PALIC to obtain your Protected Health Information (PHI) from other covered entities so that we may determine payment of a claim for specified benefits involving you.

Effect of Declining: If you decide not to sign this authorization, we may decline to approve your application for health insurance or to provide benefits.

This authorization may facilitate our consideration of a claim. If you decide not to sign this authorization, it may delay the processing of a claim.

Effect of Granting this Authorization: The PHI to be used and/or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

Expiration: This authorization will expire upon the termination of any PALIC coverage that may be in effect.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to: Philadelphia American Life Insurance Company, P.O. Box 4884, Houston, TX. 77210-4884.

I understand that revocation of this authorization will not affect any action PALIC took in reliance on this authorization before PALIC received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my Protected Health Information, as described in this authorization.

Print Name of Applicant or Claimant

Signature of Applicant or Claimant (parent if minor)

Date

If this authorization is signed by a personal representative, on behalf of the individual, complete the following:

Personal Representative: Print Name

Please indicate Representative's relationship to Applicant/Insured and briefly describe Representative's authority to act for Applicant/Insured.

Signature

Date

A photocopy of this authorization is as valid as the original, and you and your PALIC agent or broker are entitled to receive a copy of this form.

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE**

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY ○ P.O. Box 4884 ○ Houston, Texas 77210-4884

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application or information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Philadelphia American Life Insurance Company. 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 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 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 policy 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 prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. _____
- ☐ Other. (please specify) _____

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (preexisting 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 preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) 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 premium 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 that you want to keep it.

Signature of Agent or Broker

Typed Name and Address of Agent or Broker

Applicant's Signature

Date

NOTICE OF ANNUAL OPEN ENROLLMENT

Philadelphia American Life Insurance Company

P.O. Box 4884
Houston, Texas 77210

If an individual has an existing Medicare Supplement policy, the individual is entitled to an annual open enrollment period lasting 63 days, commencing with the individual's birthday.

During this period, the individual may purchase any Medicare Supplement policy with the same insurer that offers benefits equal to or lesser than those provided by the current coverage.

During this open enrollment period, an issuer of a Medicare Supplement policy shall not deny or condition the issuance or effectiveness of Medicare supplemental coverage, nor discriminate in the pricing of coverage because of health status, claims experience, receipt of health care or a medical condition of the individual.