Bankers Fidelity®

Medicare Supplement Application Package

Application Coversheet

Please use a separate coversheet for each application.

To: **Bankers Fidelity®** Underwriting Department

Fax Number: 1-404-926-4030

Email: bfluw@bflic.com

Date: _____

Producer Name: _____

Producer Phone Number: _____

Total # of pages being faxed/emailed (including this cover sheet): _____

Applicant Name: _____

Checklist:

- ❍ Application Pages (single sided)
- ❍ HIPAA Authorization (except OE/GI)
- ❍ Replacement Notice (if applicable)
- ❍ Bank Draft or Credit Card Authorization (if applicable)
- ❍ Copy of Voided Check for Bank Draft (if Draft elected)
- ❍ Copy of Initial Premium Check* (if applicable)

* Applications with an initial premium check may still be faxed or emailed in to speed up processing. After faxing or emailing the application, mail the original premium check with a copy of the first page of the application to:

Atlantic Capital Life Assurance Company™
Attn: New Business
PO Box 105185
Atlanta, GA 30348-5185

Include a note with the initial premium check stating that the application was faxed or emailed in.

Comments/Details for Underwriting team:

_____

_____

_____

_____

Log into the Agent Portal to check application status.

If you have questions about this process, please contact the Underwriting Department at 1-866-458-7501.

Bankers Fidelity Life Insurance Company®
Bankers Fidelity Assurance Company®
Atlantic Capital Life Assurance Company™
(d/b/a Bankers Fidelity)

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, GA 30348-5185
404-266-5600 or 800-241-1439

Underwriting Guidelines – Medicare Supplement

Policy Form Series B 21092 (BFLIC), B 21492 (BFAC) or A 22392 (ACLAC)

Eligible Issue Ages

65+
Under age 65 & disabled: 0-64
(U65 not available in all states)

Medical Question on Application

Answer ALL questions completely, as directed.

For Open Enrollment or 63-Day Guaranteed Issue, DO NOT answer health/medical Questions or provide the applicants Height and Weight.

Provide complete details for any "Yes" answer, where directed.

List any and all prescriptions medications the proposed insured is taking or has been told to take. If no medications are being taken or have been prescribed, write "None"; do not use N/A. (If additional space is needed for details or to list prescriptions drugs, use the additional sheet provided in the application package.)

Note: Answering 'NO' to all of the medical questions on the application does not guarantee acceptance. The Underwriter reviews the applicant's entire medical history when making their decision.

Requested issue date should be at least 30 days after the date the application is submitted to allow sufficient time to underwrite the applicant.

The underwriting decision will be accepted/rejected based on the answers to the medical questions on the application. Once the application is accepted, underwriting will use information such as MIB, prescription drug check and telephone interviews to assess the application. Telephone Interviews are done on a random basis and will be ordered by the Home Office.

Disqualifying Medications

Refer to the Disqualifying Medications list on form B3 21092 UWG IS to determine eligibility.

Underwriting & Eligibility Requirements

Simplified Issue Application

Build Chart

Random Telephone Interview – Home Office ordered

M.I.B. and Prescription Drug screen

Build Chart

Refer to Build Chart (below) to determine if the applicant is eligible for coverage.

Build Chart

Height	Decline if Under	Preferred Range	Standard Range	Decline if Over
4'2	< 65	65 - 124	125 - 146	> 146
4'3	< 67	67 - 129	130 - 152	> 152
4'4	< 70	70 - 134	135 - 158	> 158
4'5	< 72	72 - 139	140 - 164	> 164
4'6	< 75	75 - 145	146 - 171	> 171
4'7	< 78	78 - 150	151 - 177	> 177
4'8	< 81	81 - 156	157 - 183	> 183
4'9	< 84	84 - 161	162 - 190	> 190
4'10	< 87	87 - 167	168 - 197	> 197
4'11	< 90	90 - 173	174 - 204	> 204
5'0	< 93	93 - 179	180 - 210	> 210
5'1	< 96	96 - 185	186 - 218	> 218
5'2	< 99	99 - 191	192 - 225	> 225
5'3	< 102	102 - 197	198 - 232	> 232
5'4	< 105	105 - 203	204 - 239	> 239
5'5	< 109	109 - 210	211 - 247	> 247
5'6	< 112	112 - 216	217 - 255	> 255
5'7	< 115	115 - 223	224 - 262	> 262
5'8	< 119	119 - 230	231 - 270	> 270
5'9	< 122	122 - 237	238 - 278	> 278
5'10	< 126	126 - 243	244 - 286	> 286
5'11	< 130	130 - 250	251 - 294	> 294
6'0	< 133	133 - 258	259 - 303	> 303
6'1	< 137	137 - 265	266 - 311	> 311
6'2	< 141	141 - 272	273 - 320	> 320
6'3	< 145	145 - 280	281 - 329	> 329
6'4	< 148	148 - 287	288 - 337	> 337
6'5	< 152	152 - 295	296 - 346	> 346
6'6	< 156	156 - 302	303 - 355	> 355
6'7	< 160	160 - 310	311 - 364	> 364
6'8	< 164	164 - 318	319 - 374	> 374
6'9	< 168	168 - 326	327 - 383	> 383
6'10	< 173	173 - 334	335 - 393	> 393
6'11	< 177	177 - 342	343 - 402	> 402

ATLANTIC CAPITAL LIFE ASSURANCE COMPANY™
d/b/a BANKERS FIDELITY

Home Office: 4370 Peachtree Rd. NE, Atlanta, GA 30319

Application for Medicare Supplement Insurance

Agent/Producer Name	%	Agent/Producer #

Requested Effective Date: cannot be *29th, 30th or 31st*
Month ____ / Day ____ / Year ____

Deliver Policy to:
❍ Policyowner (USPS Mail)
❍ Agent/Producer (Electronic)

PROPOSED INSURED INFORMATION:

First Name	Middle Name/Initial	Last Name

Date of Birth
Month ____ / Day ____ / Year ____

Age (as of Requested Effective Date)

Place (State) of Birth

❍ Male ❍ Female

Social Security Number ____ ____ ____

CONTACT INFORMATION:

Residence Address (Street or Route & Box #)	Residence City	Residence State	Residence Zip Code
Mailing Address (if different from Residence Address)	Mailing City	Mailing State	Mailing Zip Code
Email Address	Send notices, including premium notices: ❍ electronic via email ❍ U.S.P.S.		Residence County

Home Telephone #	Mobile/Cell Telephone #	Best # to call: ❍ Home ❍ Mobile/Cell
( )	( )	Best time to call: _____ ❍ AM ❍ PM

PLAN INFORMATION:

Underwriting Class: ❍ Preferred ❍ Standard

Tobacco usage is considered Standard
(except for Open Enrollment or Guaranteed Issue applicants)

Choose One Plan: ❍ A ❍ F* ❍ G ❍ High Deductible G ❍ K ❍ N
*Only available to applicants FIRST ELIGIBLE for Medicare PRIOR to 1/1/20.

Refer to Outline of Coverage for plan availability.

OPEN ENROLLMENT / GUARANTEE ISSUE:

6-Month Open Enrollment: Are you eligible for coverage under the "Open Enrollment" period, which is the six-month period beginning with the first month in which you are both: (1) age 65 or older; and, (2) enrolled in Medicare Part B ..... ❍ Yes ❍ No

63-Day Guarantee Issue: Are you eligible for coverage under the 63-day "Guarantee Issue" period? If "Yes", proof must be submitted with this application ..... ❍ Yes ❍ No

Application continued on next page

MEDICARE INFORMATION: Please copy the following information directly from your Medicare Card.

Medicare Beneficiary Identifier: _____

Are you currently covered under or are you enrolled to be covered under:

Medicare Part A?..... ❍ Yes ❍ No **If "Yes", effective date:** _____ / _____ / _____
Month Day Year

Medicare Part B? ..... ❍ Yes ❍ No **If "Yes", effective date:** _____ / _____ / _____
Month Day Year

If "No", indicate the date you intend to enroll: _____ / _____ / _____
Month Day Year

Social Security Disability?..... ❍ Yes ❍ No **If "Yes", effective date:** _____ / _____ / _____
Month Day Year

PAYOR: To whom should premium notices be sent? ❍ Same address as Proposed Insured, or:

Payor Name:	Relationship to Proposed Insured:		Phone number: ( )
Address (Street or Route & Box #)	City	State	Zip Code
Payor's Email Address:		Send notices, including premium notices: ❍ electronic via email ❍ U.S.P.S.	

PREMIUM INFORMATION:

Household Premium Discount Rider*: Are you currently married and residing with your spouse or have you been living with at least one (1) person, but not more than three (3) persons, who are all aged 50 or over for at least the last 12 months? ..... ❍ Yes ❍ No

If "Yes", please provide the following information:

Name: _____ Relationship: ❍ Spouse ❍ Other _____

If you do not qualify for the Household Discount, the full modal premium will be required.

Initial Premium Payment:

❍ Check/Money Order included

❍ Charge Credit Card†
† Monthly Credit Card rates include a 3% surcharge.

❍ Draft Upon Approval

❍ Draft Initial Premium*
*Initial Premium Draft Date:

___ / ___ / ___
MONTH DAY YEAR

Recurring Premium Mode:

❍ Annual ❍ Semi-Annual

❍ Quarterly ❍ Monthly Direct

❍ Monthly Bank Draft*

❍ Monthly Credit Card*†
† Monthly Credit Card rates include a 3% surcharge.

*Requested Draft Day ___
cannot be 29th, 30th or 31st

Premium Calculation:

Monthly Premium (Bank Draft or Credit Card): $ _____

Household Discount*, if qualified: x _____

Equals Monthly Premium = $ _____

If Annual, Semi-Annual or Quarterly: multiply by modal factor*: x _____

If Monthly Direct Bill: add $2 service fee: + $ 2.00

Total Modal Premium: $ _____

Add One-time Policy Fee: + $25.00

Total Initial Premium Due: $ _____

For Household Discount, multiply by: .93 for 7%
**Refer to rate sheet for modal factors and the available discount percentage.*

Billing Type: ❍ Individual ❍ Family - *Complete Family Billing Form*

Cycle Billing Mode:

❍ 1st Day of the Month
❍ 3rd Day of the Month
❍ 2nd Wednesday of the Month
❍ 3rd Wednesday of the Month
❍ 4th Wednesday of the Month

Application continued on next page

OTHER HEALTH INSURANCE: Please answer the following questions regarding your current coverage.

If you've 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 have 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 you received from your prior insurer with this application. **PLEASE ANSWER ALL QUESTIONS.**

To the best of your knowledge:

1. a) Did you turn age 65 in the last 6 months? ❍ Yes ❍ No

   b) Did you enroll in Medicare Part B in the last 6 months? ❍ Yes ❍ No

   c) If "Yes", effective date: _____ / _____ / _____
   Month Day Year

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

   If "Yes",

   a) Will Medicaid pay your premiums for this Medicare Supplement policy? ❍ Yes ❍ No

   b) Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B Premium? ❍ Yes ❍ No

3. a) If you had coverage from any Medicare plan <u>other than</u> original Medicare within the last 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 date: _____ / _____ / _____ (Month Day Year) END date: _____ / _____ / _____ (Month Day Year)

   b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy for which you are applying? ❍ Yes ❍ No

   If "Yes", complete required Replacement Form. ***You must also notify your existing company.***

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

   d) Did you drop a prior Medicare Supplement plan to enroll in the Medicare plan? ❍ Yes ❍ No

4. a) Do you have another Medicare Supplement policy currently in force? ❍ Yes ❍ No

   b) If "Yes", with what company? _____

   What plan? _____

   c) If "Yes", do you intend to replace your current Medicare Supplement policy with this policy? ❍ Yes ❍ No

   If "Yes", complete required Replacement Form. ***You must also notify your existing company.***

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

   a) If "Yes", with what company? _____

   What kind of policy? _____

   b) What are your dates of coverage under the other policy?

   START date: _____ / _____ / _____ (Month Day Year) END date: _____ / _____ / _____ (Month Day Year)

   (If you are still covered under the other policy, leave "END" blank.)

Application continued on next page

IF YOU ARE ELIGIBLE FOR 6-MONTH OPEN ENROLLMENT OR 63-DAY GUARANTEE ISSUE, DO NOT ANSWER ANY PART OF QUESTIONS 6 – 14.

AGREEMENT: Please read and sign the following Agreement

I agree to provide, to the best of my knowledge and ability, responses to the questions in this application are complete, correct and true.

Proposed Insured's signature _____ Date _____

PHYSICIAN INFORMATION:

6A. Please provide the complete name, address and telephone number of your primary care physician:

Name	Telephone Number ( )
Address	

TOBACCO CLASS:

6B. In the past 2 years, have you used any type of tobacco products or any tobacco or nicotine-related products, including e-cigarettes or vaping? ..... ❍ Yes ❍ No

If "Yes", the Standard rates must be used (except for Open Enrollment or Guaranteed Issue applicants).

HEALTH INFORMATION: Please answer the following questions regarding your medical history.

7. Height: Feet ____ Inches ____ Weight: Lbs. ____

If the answer to any part of Questions 8 – 12 is "Yes", coverage is not available. DO NOT PROCEED FURTHER.

8. Are you currently, or at any time within the past 1 month have you:
   a) been hospitalized, or required assistance to perform activities of daily living, or required the use of a walker, wheelchair or motorized mobility aid? ..... ❍ Yes ❍ No
   b) received any occupational, speech, or physical therapy from a medical professional? ..... ❍ Yes ❍ No
   c) been confined to a bed, nursing facility or assisted living facility, or received home health care? ..... ❍ Yes ❍ No

9. Do you currently have or at any time in the past 6 months have you:
   a) had an implanted cardiac defibrillator for an arrhythmia? ..... ❍ Yes ❍ No
   b) required over 50 units of insulin per day for treatment of diabetes? ..... ❍ Yes ❍ No
   c) required the use of supplemental oxygen (including for obstructive sleep apnea)? ..... ❍ Yes ❍ No
   d) had disabling arthritis or arthritis that restricts mobility? ..... ❍ Yes ❍ No
   e) had angina (chest pain due to heart disease)? ..... ❍ Yes ❍ No
   f) had hepatitis C? ..... ❍ Yes ❍ No
      Do not answer "Yes" if you were treated successfully, no longer have hepatitis C, and do not have cirrhosis or other liver damage.
   g) been treated by infusions or injections administered in a medical facility for any condition (excluding those for allergies, vitamin B12, osteoporosis, or knee pain)? ..... ❍ Yes ❍ No
   h) been advised by a medical professional to have any surgery, medical tests (excluding those for routine care), medical treatments, or do you have pending diagnostic evaluations that have not yet been completed? ..... ❍ Yes ❍ No

10. In the last 2 years, have you:
   a) had any part of your body amputated due to disease? ..... ❍ Yes ❍ No
   b) been hospitalized or required the services of a psychologist, psychiatrist, or counselor for depression or any other mental or nervous condition? ..... ❍ Yes ❍ No
   c) had a new onset of heart attack, stroke, or transient ischemic attack (TIA)? ..... ❍ Yes ❍ No
   d) had surgery for any heart or circulatory disease (excluding maintenance on a previously installed pacemaker, or treatment for varicose veins)? ..... ❍ Yes ❍ No
   e) had a fracture due to osteoporosis? ..... ❍ Yes ❍ No

11. In the last 2 years, have you been diagnosed with or treated by a medical professional for any of the following:
    a) cancers or tumors? (check all that apply) ..... ❍ Yes ❍ No
       ❍ Hodgkin's disease ❍ any internal cancer ❍ malignant melanoma
    b) alcohol or drug abuse or dependency? ..... ❍ Yes ❍ No
    c) peripheral vascular disease (PVD) or peripheral arterial disease (PAD)? ..... ❍ Yes ❍ No
    d) Crohn's disease or ulcerative colitis? ..... ❍ Yes ❍ No
    e) atrial fibrillation? ..... ❍ Yes ❍ No
    f) spinal stenosis? ..... ❍ Yes ❍ No

12. Within the last 10 years have you ever had, or been diagnosed with or treated by a medical professional for any of the following:
    a) diabetes with a history at any time in the past of the following? (check all that apply) ..... ❍ Yes ❍ No
       ❍ retinopathy affecting vision ❍ neuropathy ❍ nephropathy
       ❍ skin ulcers ❍ surgery for circulatory disease ❍ heart attack
       ❍stroke or transient ischemic attack (TIA)
    b) organ transplant or have you been advised to have an organ transplant or are you waiting to have an organ transplant (excluding corneal transplant)? ..... ❍ Yes ❍ No
    c) Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? ..... ❍ Yes ❍ No
    d) any of the following diseases or disorders? (check all that apply) ..... ❍ Yes ❍ No

❍chronic bronchitis	❍ chronic obstructive pulmonary disease (COPD)
❍ emphysema	❍ any other chronic respiratory disorder (excluding asthma)
❍ cardiomyopathy	❍ congestive heart failure (CHF)
❍ chronic kidney disease	❍ end-stage renal (kidney) disease
❍ kidney/renal failure or insufficiency	❍ dialysis or been advised to have dialysis
❍ chronic hepatitis B	❍ fibrosis of the liver
❍ cirrhosis of the liver	❍ sickle cell anemia
❍ muscular dystrophy	❍ multiple sclerosis
❍ Parkinson's disease	❍ rheumatoid arthritis
❍ systemic lupus	❍ systemic scleroderma
❍ Myasthenia Gravis	❍ Lou Gehrig's disease (amyotrophic lateral sclerosis, ALS)
❍ myeloma	❍ leukemia
❍ non-Hodgkin's lymphoma	❍ any form of metastatic cancer
❍ Alzheimer's disease	❍ dementia
❍ organic brain syndrome	❍ bi-polar disorder
❍ manic-depressive disorder	❍ schizophrenia

STANDARD: If the answer to any part of Question 13 is "Yes", Standard rates apply.

13. At any time in the last 6 months, have you been diagnosed with or treated by a medical professional for any of the following:
    a) diabetes with no complications, and require 50 or less units of insulin per day? ..... ❍ Yes ❍ No
    b) macular degeneration not requiring injections? ..... ❍ Yes ❍ No
    c) obstructive sleep apnea requiring a CPAP or for which a CPAP has been recommended? ..... ❍ Yes ❍ No
    d) cardiac arrhythmia requiring a pacemaker? ..... ❍ Yes ❍ No
    e) osteoporosis treated by infusion? ..... ❍ Yes ❍ No

Application continued on next page

MEDICATION INFORMATION (attach and sign additional sheet if necessary):

14. List any type of condition for which you have received any type of treatment in the last 1 year, including prescription drugs, therapy, counseling, injections, or infusions. Provide approximate date of onset for conditions to the best of your knowledge. ***If "NONE", so state; do not leave blank or answer not applicable or N/A.***

Treatment Name	Condition for Which Prescribed	Date of Onset	Currently Taking?
			❍ Yes ❍ No
			❍ Yes ❍ No
			❍ Yes ❍ No
			❍ Yes ❍ No
			❍ Yes ❍ No
			❍ Yes ❍ No
			❍ Yes ❍ No
			❍ Yes ❍ No
			❍ Yes ❍ No
			❍ Yes ❍ No
			❍ Yes ❍ No
			❍ Yes ❍ No
			❍ Yes ❍ No
			❍ Yes ❍ No
			❍ Yes ❍ No

15. NOTICE TO THE PROPOSED INSURED:

a) You do not need more than one Medicare supplement policy. **b)** If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. **c)** You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. **d)** 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. **e)** 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. **f)** 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).

Application continued on next page

16. I, the undersigned Proposed Insured, hereby apply to Atlantic Capital Life Assurance Company™ (hereinafter referred to as "the Company") for a Policy to be issued in reliance upon my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, complete, correct and true. I understand that the answers to the questions in this application and any medical information obtained and reviewed by the Company are the basis for any policy issued by the Company. I further understand that no answer will be considered to have been given by me unless it is stated in this application. No agent or sales representative is authorized to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

I agree the Policy shall not be effective unless it has actually been issued, received by me and the first premium paid and honored by the financial institution upon which it is drawn on the first presentation, all during my lifetime and before any change in my health as stated herein.

To determine my eligibility for the coverage applied for herein, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, or other organization, institution or person, that has records or knowledge of me or my health, to give to Atlantic Capital Life Assurance Company or its reinsurer any such information. A photographic copy of this authorization shall be as valid as the original. This authorization terminates the earliest of: 1) twelve (12) months from the date of this application; 2) expiration of the time limit permitted by the state where the Policy is issued; or 3) the date it is revoked in writing by me.

Acknowledgement regarding electronic communications: Proper identification will be required for all electronic communications and transactions. Atlantic Capital Life Assurance Company will be held harmless for any claim, liability, loss or cost, when we have used reasonable procedures to confirm communications and transactions are authorized and genuine and those procedures have been followed. The Proposed Insured hereby states s/he has access to the Internet for the purposes of accepting electronic delivery of such documents or transactions, which may involve, but is not limited to, premium payments, billing changes, beneficiary changes, or contact information. Atlantic Capital Life Assurance Company will provide a digital method by which the Proposed Insured can provide a current Internet email address.

❍ By checking this box, I authorize Atlantic Capital Life Assurance Company to provide the electronic communications described herein.

The undersigned Proposed Insured and Producer state that the Proposed Insured has read or had read to him the completed application and that the Proposed Insured realizes that any false statement or material misrepresentation in the application may result in loss of coverage under the policy, subject to the "Time Limit On Certain Defenses" provision of the policy.

CAUTION: If the answers on this application are materially incorrect or untrue, the Company may have the right to deny benefits or contest your policy, subject to the "Time Limit On Certain Defenses" provision of the Policy. ANSWER ALL QUESTIONS COMPLETELY, CORRECTLY AND TRUTHFULLY.

WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I have received an outline of coverage and a "Guide To Health Insurance For People With Medicare"

Dated at _____ (City and State) ,on _____ (Month/Day/Year) X _____ Proposed Insured's signature. Read item 16 before signing

X _____ Writing Agent's/Producer's signature

Application continued on next page

WRITING AGENT/PRODUCER INFORMATION

Is this Medicare Supplement policy being purchased to replace any existing Medicare plan or an existing Medicare Supplement policy? **If "Yes," complete Replacement Notice.** ..... ❍ Yes ❍ No

I have sold the following health insurance policies to the Proposed Insured which are still in force: _____

_____

I have sold the following health insurance policies to the Proposed Insured within the past 5 years which are no longer in force: _____

_____

Did you meet with the Proposed Insured in person? ..... ❍ Yes ❍ No

Did you complete this application over the phone? ..... ❍ Yes ❍ No

Did you ask the Proposed Insured each question exactly as written? ..... ❍ Yes ❍ No

Did you review this application for correctness and any omissions? ..... ❍ Yes ❍ No

Did the Proposed Insured review this application for correctness and any omissions? ..... ❍ Yes ❍ No

Was any other person present when this application was taken? ..... ❍ Yes ❍ No

If "Yes", Name: _____ Relationship to applicant: _____

Is the Proposed Insured related to you?

If "Yes", explain relationship: ❍ Self ❍ _____

I, the undersigned Producer, certify that: (1) I have personally interviewed the Proposed Insured; (2) I asked the Proposed Insured each question exactly as it appears on this application; (3) I have truly and accurately recorded the information supplied by the Proposed Insured with no omissions or alterations; and (4) I have given the Proposed Insured an Outline of Coverage for the policy applied for and a "Guide To Health Insurance For People With Medicare."

Dated on _____ X _____
(Month/Day/Year) Writing Agent's/Producer's signature

ATLANTIC CAPITAL LIFE ASSURANCE COMPANY™

4370 Peachtree Road, NE, Atlanta, Georgia 30319

AUTHORIZATION TO RELEASE MEDICAL INFORMATION IN COMPLIANCE WITH HIPAA

In order for Atlantic Capital Life Assurance Company™ (or its affiliates or reinsurers) to evaluate my application for insurance, or if a policy is issued, to evaluate contestability or eligibility for payment of claims benefits and for the continuation or replacement of the policy, I hereby authorize any and all medical practitioners, physicians, nurses, pharmacists, hospitals, clinics, long-term care facilities, medical or medically-related facilities, laboratories, insurance companies and insurance support organizations (i.e.: the MIB Group), records custodians or anyone else with knowledge of me or my health to release any and all records and information within your possession, custody or control to Atlantic Capital Life Assurance Company or its authorized representative.

Information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released. Such records and information may include, but is not limited to, the following: alcohol and/or drug abuse treatment, psychiatric treatment (except psychotherapy notes), prescription drug information or STD or other communicable disease testing and treatment.

Atlantic Capital Life Assurance Company cannot process an application for insurance without this signed Authorization. Furthermore, determination of eligibility for payment of claims benefits will be based upon information obtained in accordance with this authorization. Failure to authorize us to obtain information from all necessary providers may result in a delay of your claim due to lack of complete information.

I UNDERSTAND:

1. Health information about me provided to Atlantic Capital Life Assurance Company™ is protected by federal privacy regulations and that Atlantic Capital Life Assurance Company™ will only use and disclose such information as allowable by law. However, I also understand that, upon disclosure pursuant to this authorization to any person or organization that is not covered by the federal privacy regulations (i.e. an insurance regulatory or other government agency), the disclosed information may no longer be protected by those regulations.
2. I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon this authorization or to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to Atlantic Capital Life Assurance Company™ at the address above. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment or business operations.
3. Atlantic Capital Life may release information obtained through this Authorization to its reinsurers, the MIB or other insurance companies as allowable by law.
4. I am entitled to receive a copy of this authorization.
5. A photographic copy of this authorization is as valid as the original.
6. This authorization will expire 24 months from the date signed.

Dated at _____ on _____

_____ Patient's Signature	_____ Patient's Printed Name	_____ Patient's Date of Birth
_____ Patient's Resident Address	_____ Patient's Social Security Number	_____ Patient's Phone Number
_____ Personal Representative's Signature	_____ Representative's Printed Name	_____ Relationship to Patient*

*Describe Personal Representative's authority or relationship to Patient. If Power of Attorney, must provide copy of POA papers.

BANKERS FIDELITY LIFE INSURANCE COMPANY®
BANKERS FIDELITY ASSURANCE COMPANY®
ATLANTIC CAPITAL LIFE ASSURANCE COMPANY™

4370 Peachtree Road, NE, Atlanta, Georgia 30319

Authorization for Release of Information to My Insurance Agent and/or Agency

In the event that my application is declined or my premiums are rated higher than I applied for, I authorize Bankers Fidelity Life Insurance Company® and their affiliated companies, or their authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Bankers Fidelity Life Insurance Company and their affiliated companies or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Bankers Fidelity Life Insurance Company may have taken based on this information.

The information will be used to help me with the insurance application process or to find other insurance coverage options. I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. I understand that I may refuse to sign this authorization. My refusal to sign it will not affect the Company's decision to issue the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 60 days from the date I sign it.

I understand that I may revoke this authorization at any time, by written notice to:

Bankers Fidelity Life Insurance Company
ATTN: Underwriting
4370 Peachtree Rd NE
Atlanta, GA 30319

I realize that my right to revoke this authorization is limited to the extent that Bankers Fidelity Life Insurance Company has taken action in reliance on the authorization and does not affect any disclosures made prior to the receipt of the revocation of the authorization.

Proposed Insured's Signature	Printed Name	Date
Spouse's Signature (if applying for coverage)	Printed Name	Date

AUTHORIZATION TO HONOR RECURRING DRAFTS/WITHDRAWALS/CHARGES MADE BY AND PAYABLE TO ATLANTIC CAPITAL LIFE ASSURANCE COMPANY™, ATLANTA, GA

I hereby authorize you to pay from and charge to my account listed below any draft, withdrawal or charge, including electronic transactions, made by and payable to Atlantic Capital Life Assurance Company™, Atlanta, GA for the premiums due on my insurance policy, provided there are sufficient funds in said account to honor such draft, withdrawal or charge upon presentation. I agree that your rights in respect to each draft, withdrawal or charge shall be the same as if it were a check, withdrawal or charge made personally by me.

This authorization shall remain in effect until Atlantic Capital Life Assurance Company™ has received written notification from me revoking this authorization and in such manner as to afford reasonable opportunity to act upon it. I agree that if any draft, withdrawal or charge is dishonored or refused, you shall be under no liability whatsoever, even if such dishonor or refusal results in the forfeiture of insurance.

Complete appropriate section according to your payment method

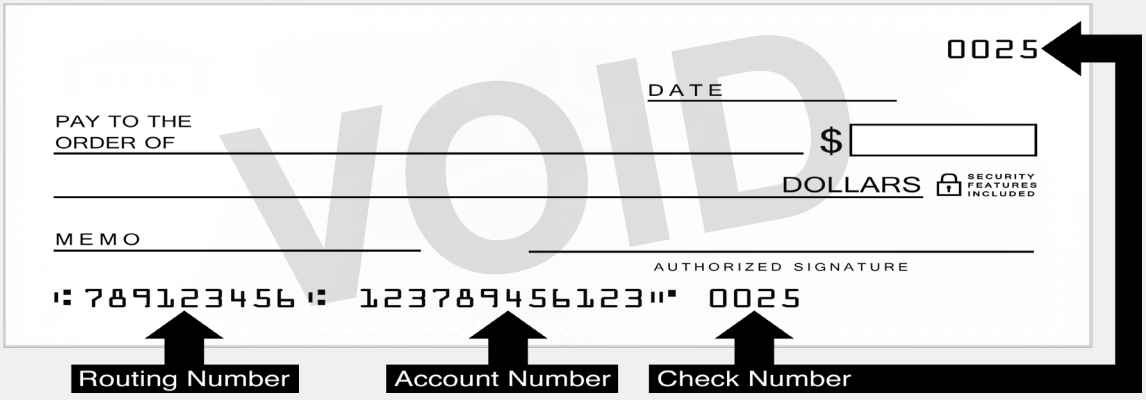
A. ❒ CREDIT CARD AUTHORIZATION

Type of Card: ❒ Mastercard ❒ Visa ❒ Discover ❒ American Express	Account Number:
Name of Card Holder as it appears on account	Expiration Date ____ / ____ Month Year
Signature of Card Holder	Date

B. ❒ CHECKING AUTHORIZATION ❒ SAVINGS ACCOUNT AUTHORIZATION

Name of Financial Institution:	
Routing/ABA Number:	Account Number:
Signature of Account Holder	Date

Attach a voided check. If the authorization is for a Savings Account, attach a deposit slip.



B 0129 MBD/CC (9-20)

COMPLETE FOR FAMILY BILLING/LIST BILL

Multiple policies can be paid on a single automatic draft from the same account or billed on a single billing notice. The policies can be on one person or multiple insureds, as long as they are billed on the same day. To set up Family Billing, we will need the following information:

NOTE: Family Billing/List Bill must have the same Payor for all policies listed.

Name of Payor:	Social Security Number
	___ — ___ — ____

Policy # (if existing policy)	Name of Primary Insured	Premium Amount
	Total Premium	$

Signature of Payor _____ Date _____

A 0129 FB/LB (2-11)

NOTICE TO THE APPLICANT
PART ONE

Federal law requires that notice of investigation be given to persons applying for insurance.

In making this application for insurance to Atlantic Capital Life Assurance Company™, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of the investigation. None of the information collected concerning the sexual orientation of the Proposed Insured will be used to determine his or her eligibility for insurance.

PART TWO

Information regarding your insurability will be treated as confidential. Atlantic Capital Life Assurance Company™ or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as the 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 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Atlantic Capital Life Assurance 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.

COMPLETE THIS RECEIPT ONLY IF INITIAL PREMIUM IS COLLECTED WITH THE APPLICATION.

Atlantic Capital Life Assurance Company™

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, Georgia 30348-5185

PREMIUM RECEIPT

Received from _____ the sum of $ _____ being payment on account of an application for insurance to the Atlantic Capital Life Assurance Company™, which application bears the same date as this receipt. This receipt is for: _____ policy. Proposed insured: _____

The insurance applied for shall not take effect until a policy issued on the basis of the above mentioned application shall have been delivered to the proposed insured, and the full first premium paid, all during the lifetime and before any change in the insurability of the proposed insured as stated in the application. Otherwise, there shall be no liability on the part of the Company except to refund this payment upon surrender of this receipt.

Date _____ Agent _____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.
THIS RECEIPT IS NOT VALID IF INITIAL PREMIUM IS PAID BY CREDIT CARD.

DETACH AND LEAVE THIS PAGE WITH THE APPLICANT.