P.O. Box 14399
Lexington, KY 40512-9700
800-264-4000
aetnaseniorproducts.com

Application

Medicare Supplement Insurance

Underwritten by

An Aetna Company **American Continental Insurance Company**

North Dakota

American Continental Insurance Company
An Aetna Company

P.O. Box 14399
Lexington, KY 40512-9700

Application for Medicare Supplement Insurance
from American Continental Insurance Company

- Print clearly and use blue or black ink.

1. Proposed insured information

Write the name as stated on the Medicare card. Provide a copy of the Medicare card with the application if possible.

Full name of proposed insured *First, M.I., Last*

Address

Phone

City

State

Zip

E-mail

Social Security Number

Write the date of birth that is on the birth certificate.

Birth date *mm/dd/yyyy*

Age

Height *Feet and inches*

Weight *Pounds*

○ Male ○ Female

Are you a legal resident of the United States? ○ Yes ○ No

Have you used any form of tobacco in the past 12 months? ○ Yes ○ No

Include any letters associated with the Medicare number and in the appropriate position. If applicant has not received a Medicare card yet, put "No Medicare number yet".

Medicare card number

Date enrolled in: Medicare Part A

Medicare Part B

For Agent Use Only:

Check one if application is for: ○ Open Enrollment ○ Guaranteed Issue

2. Plan and premium information

Plan selected:

Requested Medicare Supplement effective date: *mm/dd/yyyy*

You have a choice among several payment options or modes for paying your premium (annual, semi-annual, quarterly and monthly electronic funds transfer).

Annual premium:
$

Modal premium:
$

Policy fee:
$

Total modal premium collected/draft:
$

Payment mode
○ Annually ○ Quarterly
○ Semi-Annually ○ Monthly EFT (Electronic Funds Transfer)

PAYMENT MODES

Each payment mode, other than annual and monthly electronic funds transfer, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates. The annual and monthly electronic funds transfer modes have the same and lowest total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You may change your payment mode, among the modes available, during the life of your policy.

3. Eligibility questions

Please answer all questions.

To the best of your knowledge:

1. Did you turn age 65 in the last 6 months? ○ Y ○ N
   A. Did you enroll in Medicare Part B in the last 6 months? ○ Y ○ N
   B. If yes, what is the effective date?
   . / /

NOTE: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to question 2.

2. Are you covered for medical assistance through the state Medicaid program? ○ Y ○ N
   A. If yes: Will Medicaid pay your premiums for this Medicare Supplement policy? ○ Y ○ N
   B. Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium? ○ Y ○ N

3. 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 date . / / End date . / /
   A. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ○ Y ○ N
   B. Was this your first time in this type of Medicare plan? ○ Y ○ N
   C. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ○ Y ○ N

4. Do you have another Medicare Supplement policy inforce? ○ Y ○ N
   A. If so, with what company, and what plan do you have?
   Company . Plan .
   B. If so, do you intend to replace your current Medicare Supplement policy with this policy? ○ Y ○ N

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.

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ○ Y ○ N
   A. If so, with what company, and what kind of policy?
   Company . Plan .
   B. What are your start and end dates of coverage under the other policy? (If you are still covered under the other policy, leave "End" blank.)
   Start date . / / End date . / /

4. Health questions

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

If the health questions are answered for an Open Enrollment or Guaranteed Issue application, the application cannot be processed and will be returned.

If any health questions are answered "yes" in Section 4, the applicant does not qualify for this insurance with us.

1. Are you dependent on a wheelchair or any motorized mobility device?	○ Y	○ N
2. Do any of the following apply to you?		
Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy	○ Y	○ N
3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. congestive heart failure, unoperated aneurysm, defibrillator	○ Y	○ N
B. leukemia, lymphoma, multiple myeloma, cirrhosis	○ Y	○ N
C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy	○ Y	○ N
D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease	○ Y	○ N
E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	○ Y	○ N
F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV)	○ Y	○ N
4. Do you have diabetes?		
A. that requires use of insulin	○ Y	○ N
B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage	○ Y	○ N
C. with history of heart attack or stroke (at any time)	○ Y	○ N
D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	○ Y	○ N
5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. alcoholism, drug abuse	○ Y	○ N
B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder	○ Y	○ N
C. internal cancer, melanoma, Hodgkin's Disease	○ Y	○ N
D. hepatitis, disorder of the pancreas	○ Y	○ N
6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease	○ Y	○ N
B. myasthenia gravis, systemic lupus or connective tissue disorder	○ Y	○ N
C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	○ Y	○ N
D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder	○ Y	○ N
E. any lung or respiratory disorder and currently use tobacco products	○ Y	○ N
7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or any surgery that has not been performed?	○ Y	○ N
8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?	○ Y	○ N

9. Within the past 12 months, do any of the following apply to you?		
A. had a pacemaker implanted	○ Y	○ N
B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer	○ Y	○ N
C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer	○ Y	○ N
D. had a seizure	○ Y	○ N
10. Was your last blood pressure reading higher than 175 Systolic or higher than 100 Diastolic?	○ Y	○ N

Systolic is the upper number and Diastolic is the bottom number of a blood pressure reading.

5. Health history

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

2. Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

3. **Prescribed medications**	**Reason for medications (diagnosis)**

Use an additional sheet of paper if needed for explanation.

6. Physician information

Your primary physician Phone

Physician's office name

City State

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Have you seen any additional physicians other than those listed above in the past 24 months? ○ Y ○ N

7. Important statements

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 the suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be 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.
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).

8. Privacy notice

Although your application is our initial source of information, we may collect information, including health history and medical records, from persons other than you and we may conduct a telephone interview with you. American Continental Insurance Company, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

9. Producer compensation

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

10. Applicant agreement

I hereby apply to American Continental Insurance Company for a policy to be issued in reliance on my written answers to the questions on this application. I have read and understand all statements and answers and certify that to the best of my knowledge and belief, they are true, complete and correctly recorded. I acknowledge that I have received an outline of coverage for the policy applied for and *A Guide to Health Insurance for People with Medicare*.

I agree (1) this application and any policy issued will constitute the entire contract of insurance and the Company will not be bound in any way by any statements, promises or information made or given by or to any agent or other person at any time unless the same is in writing and submitted to the Company at its Home Office and made a part of such contract. Only a Company Officer can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing; and (2) the policy shall not be effective until it has actually been issued by the Company and said policy is manually received and accepted by me and the first premium paid, and there has been no change in my health as stated in the application.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand that if any answers on this application are incorrect, incomplete or untrue, American Continental Insurance Company has the right to adjust my premium, reduce my benefits or rescind the policy.

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

Applicant signature	Date signed
X	.

11. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Proposed insured's name

▪

Account owner name, if different than proposed insured's

▪

Account owner relationship to proposed insured:

◯ Business owned by proposed insured ◯ Living trust ◯ Employer
◯ Power of Attorney ◯ Conservator/guardian
◯ Family member; specify ▪

Financial institution name

▪

◯ Checking ◯ Savings

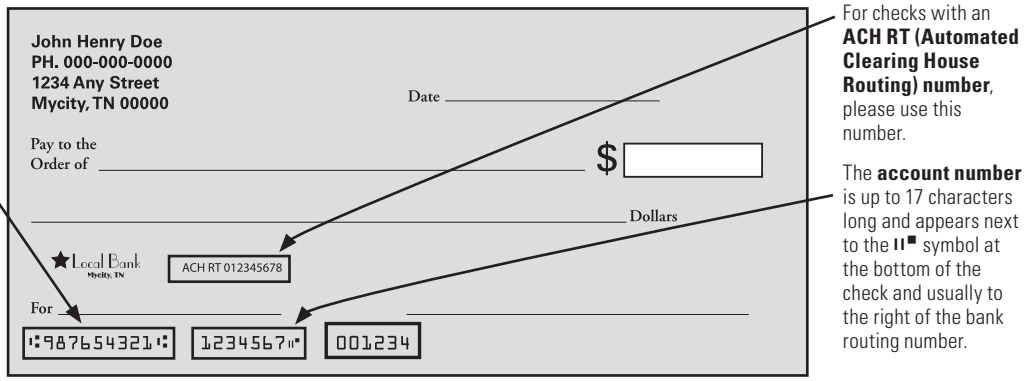
Routing number

▪

Account number

▪

This is an example of a personal check. A business check may be different.



For all other checks, use the nine-character bank **routing number**, which appears between the ⑆ symbols, usually at the bottom left corner of the check.

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the ⑈ symbol at the bottom of the check and usually to the right of the bank routing number.

12. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner

X ▪

Date

▪

13. Agent

All information **must** be completed.

Please list any other medical or health insurance policies sold to the proposed insured.

1) List policies sold which are still in force

.

.

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

.

.

I certify that:

1. I have accurately recorded the information supplied by the applicant.
2. The application was provided to the applicant to review and the applicant has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy.
3. I have provided an outline of coverage for the policy applied for and *A Guide to Health Insurance for People with Medicare* to applicant prior to completing the application.

The writing number reflects where commissions will be paid.

Agent name *Printed*	Writing number (agent or company)
.	.
Agent signature	State license ID number (for FL only)
X	.
Phone	E-mail
.	.

14. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through American Continental Insurance Company (ACI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACI commission schedule.

Agent Information *Print*

Writing Agent		Percentage
.		. %
Secondary Agent	Writing number	Percentage
.	.	. %

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing Agent Signature

X

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An Aetna Company

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office hours 7:00 a.m. - 7:00 p.m. CST

Receipt
from American Continental Insurance Company

- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.

Proposed insured's name *Printed*

Date of application

Initial payment collected (if applicable)

$ ◯ Check ◯ Money order

EFT draft amount

$

This acknowledges receipt of your application for an American Continental Insurance Company Medicare Supplement insurance policy.

Agent name *Printed*

Phone

Signature of agent

X

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to American Continental Insurance Company.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

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

Thank you for choosing American Continental Insurance Company!