APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

For Seniors with Medicare Parts A and B

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

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 _____

Name (as it appears on your Medicare card) _____

Social Security Number | | | | | | | | | | 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	**Applicant (other than Newly Eligible Applicant)**
Medicare Supplement Standard Plans:	Medicare Supplement Standard Plans:
☐ A ☐ G	☐ A ☐ C ☐ F ☐ F (High Deductible)
☐ G (High Deductible) ☐ M ☐ N	☐ G ☐ G (High Deductible) ☐ M ☐ N

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?	☐	☐
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?	☐	☐
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?	☐	☐
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?	☐	☐
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)?	☐	☐
c. Chronic Obstructive Pulmonary Disease (COPD), asbestosis, or emphysema?	☐	☐
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?	☐	☐
5. Do you have diabetes:		
a. With complications including, retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage?	☐	☐
b. Treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar?	☐	☐
c. With uncontrolled high blood pressure in the past 2 years?	☐	☐
d. With the use of insulin in the past 5 years?	☐	☐
6. In the past 12 months have you had placement of a pacemaker or had a joint replacement?	☐	☐
7. Within the past 2 years, have you been confined in a facility for drug or alcohol abuse or a mental/nervous condition?	☐	☐
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?	☐	☐
9. Have you been treated for degenerative disc disease in the past 2 years?	☐	☐
10. Do you need the assistance of a wheelchair, cane, or walker for mobility purposes?	☐	☐

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.

Warning: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

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): _____

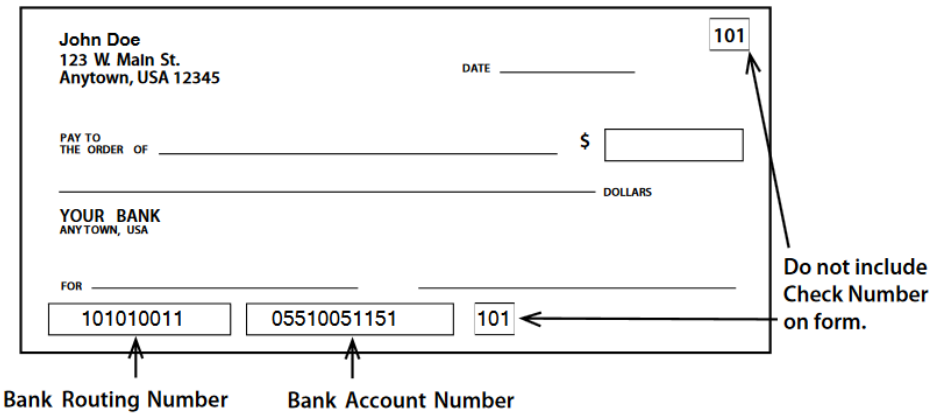
Draft date will be the same day as the effective date's day unless a preferred date is indicated.

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



FOR AGENT ONLY

Please list any other health insurance policies or coverages sold to the applicant which are still in force, and any other health insurance policies or coverages 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

2nd Agent No.

Send Policy To: ☐ Agent ☐ Insured

SENIOR SERVICES TOLL-FREE NUMBER

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

(877) 417-7555

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.

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

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: _____

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

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 REPLACMENT
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. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration and acceptance by the replacing issuer, 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 reasons:

_____ 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