

MEDICARE SUPPLEMENT

Insurance Application



FINANCIAL RESOURCES

Supplemental Benefits Group

Our Companies include:

Central Reserve Life Insurance Company
Continental General Insurance Company
Great American Life Insurance Company®
Loyal American Life Insurance Company®
Provident American Life and Health Insurance Company
United Teacher Associates Insurance Company



MEDICARE SUPPLEMENT INSURANCE APPLICATION TO (must select one below):

- CENTRAL RESERVE LIFE INSURANCE COMPANY – P.O. Box 559015 – Austin, TX 78755-9015
- CONTINENTAL GENERAL INSURANCE COMPANY - P.O. Box 559015 – Austin, TX 78755-9015
- GREAT AMERICAN LIFE INSURANCE COMPANY® - P.O. Box 559015 – Austin, TX 78755-9015
- LOYAL AMERICAN LIFE INSURANCE COMPANY® - P.O. Box 559015 – Austin, TX 78755-9015
- PROVIDENT AMERICAN LIFE & HEALTH INSURANCE COMPANY - P.O. Box 559015 – Austin, TX 78755-9015
- UNITED TEACHER ASSOCIATES INSURANCE COMPANY - P.O. Box 559015 – Austin, TX 78755-9015

Agent Name _____ Agent Writing # _____ New Business Reinstatement Benefit Change

Name of Proposed Insured (Print)				Have you used tobacco within the last 12 months?		Gender	
Last	First	Middle Initial		Yes <input type="checkbox"/> No <input type="checkbox"/>		M <input type="checkbox"/> F <input type="checkbox"/>	
Height	Weight	Date of Birth		Age	Social Security No.		Medicare Card No.
		Mo.	Day	Year		-	-
Resident Street Address (No P. O. Box)				City		State	Zip
Mailing Address (if different from above)				City		State	Zip
Telephone No. () -				E-mail Address			

COVERAGE APPLIED FOR

<p>Check plan selected (plan availability varies by company):</p> <p><input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan F* (High Deductible)</p> <p><input type="checkbox"/> Plan B <input type="checkbox"/> Plan G <input type="checkbox"/> Plan J* (High Deductible)</p> <p><input type="checkbox"/> Plan C <input type="checkbox"/> Plan H <input type="checkbox"/> Plan K</p> <p><input type="checkbox"/> Plan D <input type="checkbox"/> Plan I <input type="checkbox"/> Plan L</p> <p><input type="checkbox"/> Plan E <input type="checkbox"/> Plan J</p> <p>Rate Class: <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Standard</p> <p>Requested Effective Date: _____</p> <p>Modal Premium: \$ _____ Enrollment Fee: \$ _____</p> <p>Amount Enclosed: \$ _____</p>	<p>Check premium payment mode selected:</p> <p><input type="checkbox"/> Annual <input type="checkbox"/> Direct <input type="checkbox"/> Bank Draft</p> <p><input type="checkbox"/> Semi-Annual <input type="checkbox"/> Direct <input type="checkbox"/> Bank Draft</p> <p><input type="checkbox"/> Quarterly <input type="checkbox"/> Direct <input type="checkbox"/> Bank Draft</p> <p><input type="checkbox"/> Monthly Bank Draft</p> <p><input type="checkbox"/> Draft bank account for 1st premium</p> <p><input type="checkbox"/> Check enclosed for 1st premium</p> <p style="text-align: right;">Make checks payable to the insurance company.</p>
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A. 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. (Please mark Yes or No below with an "X".)

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

If yes, what is the effective date? _____

2. 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 Costs", please 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 toward your Medicare Part B premium? Yes No

3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? Yes No

If "Yes":

a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ____/____/____ END ____/____/____

- b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?..... Yes No
- c) Was this your first time in this type of Medicare plan? Yes No
- d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No
- 4.a) Do you have another Medicare supplement policy in force? Yes No
- b) If so, with what company and what type of plan? _____

c) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No
If existing Medicare supplement coverage is not to be replaced, this policy cannot be issued.

5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? Yes No
- a) If so, with what company and what kind of policy? _____

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

B. Do you now have Medicare Parts A and B?..... Yes No
 If yes, give effective date of Part B: _____.

C. If Medicare Parts A and B are to be effective at a future date, provide the date both Medicare Parts A and B will be effective _____.

NOTE – Medicare effective date is always the 1st day of the month. Applicant must have both Medicare Parts A & B on the effective date of the policy. If not, coverage cannot be issued.

IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEE ISSUE (BASED ON YOUR ANSWERS IN PART A-C), DO NOT ANSWER THE QUESTIONS IN SECTIONS D-E.

D. If the answer to any question in this section is "Yes" the proposed insured is not eligible for coverage.

- | | | |
|---|--------------------------|--------------------------|
| 1. Are you currently confined in a hospital or nursing facility, or receiving the services of a home health agency? | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you require or receive any assistance with any of your activities of daily living such as bathing, transferring, toileting, eating, dressing, or continence?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently bedridden or do you use the assistance of a wheelchair, walker, or motorized mobility aid?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Within the past two (2) years have you: | | |
| a. Been hospitalized more than 2 times or received home health care services more than 3 times? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been confined to a nursing facility for more than 30 days?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been diagnosed with, treated for, or taken medication for Angina, Heart Attack, Heart or Heart Valve Surgery, Implantation of Cardiac Pacemaker or Defibrillator, Cardiomyopathy, Congestive Heart Failure, Cardiac or Vascular Angioplasty, Stent Placement, Bypass, or Endarterectomy? . | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had a Stroke or Transient Ischemic Attack (TIA)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have now, or in the last two (2) years have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions: | | |
| a. Hepatitis, Cirrhosis of the Liver or Other Liver Disease?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Major Depression, Bi-Polar Disorder, Schizophrenia, or a Paranoid Disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Insulin Dependent Diabetes; Diabetes with Neuropathy, Retinopathy, or Vascular Disease; Chronic Kidney Disease; Renal Insufficiency; Renal Failure; or any Kidney Disease requiring dialysis?... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Alcohol or Drug Abuse?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Paralysis, Hemophilia, Osteoporosis with fractures, or unrepaired Aneurysm? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Paget's Disease, Rheumatoid or Disabling Arthritis, Lupus or other Connective tissue disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have now, or at any time have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions: | | |
| a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Dementia, Senility, Alzheimer's Disease, or Organic Brain Disorder? | <input type="checkbox"/> | <input type="checkbox"/> |

Yes No

- b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) Infection?
- c. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic Obstructive Lung Disease (COLD) excluding Asthma? Or any Chronic Pulmonary Disease requiring the use of oxygen? ..
- d. Amputation caused by disease or organ transplant other than corneas?

7. Has surgery been advised but not performed or any surgery anticipated, including cataract surgery?

8. Have medical tests, treatment, or therapy been advised but not performed?

E. Please list any prescription or over-the-counter medications taken within the past 12 months.

Medication	Condition Taken For

Phone interviews will be used on the non-open enrollee/Guarantee Issue applicants.

Daytime Phone #(_____) _____ - _____ Best Time to Call: _____

COMMENTS:

- You do not need more than one Medicare supplement policy.
- If you purchased this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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 in Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I hereby apply to the company indicated on page 1 of this application for insurance ("the Company") to be issued upon the truth and completeness of the answers to the above questions to the best of my knowledge, and agree that: (1) No agent has the authority to waive the answer to any question in the application; and (2) no insurance will be effective until a policy has been issued.

AUTHORIZATION

I hereby authorize any health care provider, including any physician, practitioner, pharmacy, prescription vendor, pharmacy benefit manager, hospital or medically-related facility, and any insurance company, the Medical Information Bureau (MIB) or other consumer reporting agency, employer, or, except in AZ, any other organization, institution or person that has my records or knowledge of me or my dependent(s) to disclose to the Company, or its authorized representative, any such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by company personnel to determine eligibility for insurance and/or benefits. The Company may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. However, the Company shall not disclose to an agent information received from MIB. The Company reserves the right to require a medical examination or testing or both. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask the Company to correct, amend or delete any incorrect personal information. A copy of the Company's "Privacy Notice and Notice of Insurance Information Practices" is available upon request. I have received the Outline of Coverage for the policy applied for and the required Guide to Health Insurance for People with Medicare.

This authorization shall be valid for a period of two (2) years from the date signed to determine eligibility for insurance or for the term of coverage of the policy to determine benefits. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to the Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke also is subject to the rights of the Company under any law granting the Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

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

Signature of Applicant

Date

Applicant's Printed Name

CAUTION: Please review your answers to the questions on this application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

MEDICARE SUPPLEMENT INSURANCE PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER APPLIES TO (must select one below):

- CENTRAL RESERVE LIFE INSURANCE COMPANY - P. O. Box 559015 – Austin, TX 78755-9015
- CONTINENTAL GENERAL INSURANCE COMPANY - P. O. Box 559015 – Austin, TX 78755-9015
- GREAT AMERICAN LIFE INSURANCE COMPANY® - P. O. Box 559015 – Austin, TX 78755-9015
- LOYAL AMERICAN LIFE INSURANCE COMPANY® - P. O. Box 559015 – Austin, TX 78755-9015
- PROVIDENT AMERICAN LIFE & HEALTH INSURANCE COMPANY - P. O. Box 559015 – Austin, TX 78755-9015
- UNITED TEACHER ASSOCIATES INSURANCE COMPANY - P. O. Box 559015 – Austin, TX 78755-9015

Proposed Insured's Name _____ Policy Number (if Available) _____

Financial Institution Name and Telephone Number _____

Financial Institution Address _____

9 Digit Routing Number _____ Account Number _____

Requested Withdrawal Date (1st thru 28th): _____

Withdraw Payment: Monthly Quarterly Semi-Annually Annually

Type of Account:

- Personal Checking Account
- Personal Savings Account
- Corporate/Business Checking

Name of Employer Group _____

Purpose for Submitting this Authorization – Check appropriate box(es):

- New authorization
- Change in checking/savings account
- Change in financial institution
- Change in existing coverage

For Checking Account:
Please tape a VOIDED check in this box.

For Savings Account:
Please attach a letter from the bank stating the account and routing number of your savings account.

TAPE VOIDED CHECK HERE 0101

PAY TO THE ORDER OF _____ \$ _____ Dollars

The Routing number is 9 digits between the **⑆** symbols.

The Account number is usually to the left of **⑆**. If check number is left of account number, ignore check number.

The Check number should match the upper right corner.

⑆ 123456789 ⑆
34567890 ⑆
0101

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to the Company selected above provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. This authorization shall 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 draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR THE COMPANY SELECTED ABOVE: It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract, and no other notice of premiums due will be given. No premium shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium payment has been received by the selected company above. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by the selected company above if any draft is not paid upon presentation. The payment of premiums under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by the company selected above upon 30 days written notice.

Print Name of Depositor (as it appears on account) _____ Signature of Depositor _____ Date _____

GREAT AMERICAN SUPPLEMENTAL BENEFITS GROUP OFFICIAL RECEIPT
UNLESS EFT/ACH FORM IS USED A CHECK OR MONEY ORDER MUST ACCOMPANY APPLICATION

Please check one of the following companies:

- | | |
|---|--|
| <input type="checkbox"/> Central Reserve Life Insurance Company | <input type="checkbox"/> Continental General Insurance Company |
| <input type="checkbox"/> Great American Life Insurance Company® | <input type="checkbox"/> Loyal American Life Insurance Company® |
| <input type="checkbox"/> Provident American Life & Health Insurance Company | <input type="checkbox"/> United Teacher Associates Insurance Company |

Received of _____ this _____ day of _____ (M) / _____ (Y), an application for a Form _____ Policy and

Check or Money order for _____ Dollars.

Should the Company decline to issue the insurance applied for, the Company hereby agrees to return the above sum to the applicant.

_____ Agent

If the full premium is paid with the application and so recorded in the application and the Company shall be satisfied after investigation that the applicant was acceptable for the insurance applied for at the time the application was signed according to the underwriting rules of the Company the policy will be dated and effective according to its terms at 12:01 A.M. the day the application was dated or the date on which the premium was paid, whichever is later.

GASBG-9-0044



Supplemental Benefits Group

11/13/08



Our Companies include:

- Central Reserve Life Insurance Company
- Continental General Insurance Company
- Great American Life Insurance Company®
- Loyal American Life Insurance Company®
- Provident American Life & Health Insurance Company
- United Teacher Associates Insurance Company

P. O. Box 559015 | Austin, TX 78755-9015

AUTHORIZATION FORM FOR DISCLOSURES OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me and my family as described below.

1. "The Company" shall mean the affiliated covered entities which are Great American Life Insurance Company's® Long Term Care Division, Loyal American Life Insurance Company®, United Teacher Associates Insurance Company, Central Reserve Life Insurance Company, Continental General Insurance Company and Provident American Life & Health Insurance Company.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, the U.S. Veterans Administration and Selective Service System, insurance company, the Medical Information Bureau, or any other organization, institution or person that has any records or information available as to the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents and premium accounting representatives any such records or information.
3. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
4. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Officer at P. O. Box 26580, Austin, TX 78755-0580.
5. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
6. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
8. If you are the representative of an applicant, describe the scope of your authority to act on the applicant's behalf:

Applicant's Name

Name of applicant's personal representative, if applicable

Applicant's Social Security Number

Relationship of personal representative of the applicant

Signature of Applicant

Date

Signature of personal representative

Date

Signature of Company's Agent

Date

A signed copy of this form will be provided with the policy if issued and any other time upon request.

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the applicant and by the agent, and submitted to the Company selected below with the application. A copy of this form must also be left with the applicant.

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

MEDICARE SUPPLEMENT INSURANCE REPLACEMENT NOTICE APPLIES TO (must select one below):

- CENTRAL RESERVE LIFE INSURANCE COMPANY - P. O. Box 559015 – Austin, TX 78755-9015
- CONTINENTAL GENERAL INSURANCE COMPANY - P. O. Box 559015 – Austin, TX 78755-9015
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- LOYAL AMERICAN LIFE INSURANCE COMPANY® - P. O. Box 559015 – Austin, TX 78755-9015
- PROVIDENT AMERICAN LIFE & HEALTH INSURANCE COMPANY - P. O. Box 559015 – Austin, TX 78755-9015
- UNITED TEACHER ASSOCIATES INSURANCE COMPANY - P. O. Box 559015 – Austin, TX 78755-9015

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

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by the Company selected above. 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 the 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 ISSUER, 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 coverage is being purchased for the following reason (check one):

- | | |
|---|---|
| <input type="checkbox"/> Additional benefits. | <input type="checkbox"/> My plan has outpatient drug coverage and I am enrolling in Part D. |
| <input type="checkbox"/> No change in benefits, but lower premiums. | <input type="checkbox"/> Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment. |
| <input type="checkbox"/> Fewer benefits and lower premiums. | <input type="checkbox"/> 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 which you may presently have (pre-existing 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 pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy 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 premiums 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 YOU WANT TO KEEP IT.

Agent's Signature

Applicant's Signature

Type or Print Name and Address of Agent or Broker

Date

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the applicant and by the agent, and submitted to the Company selected below with the application. A copy of this form must also be left with the applicant.

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

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by the Company selected above. 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 the 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 ISSUER, 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 coverage is being purchased for the following reason (check one):

- | | |
|---|---|
| <input type="checkbox"/> Additional benefits. | <input type="checkbox"/> My plan has outpatient drug coverage and I am enrolling in Part D. |
| <input type="checkbox"/> No change in benefits, but lower premiums. | <input type="checkbox"/> Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment. |
| <input type="checkbox"/> Fewer benefits and lower premiums. | <input type="checkbox"/> 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 which you may presently have (pre-existing 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 pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy 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 premiums 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 YOU WANT TO KEEP IT.

Agent's Signature

Applicant's Signature

Type or Print Name and Address of Agent or Broker

Date