

Thank you for your interest in applying for the Loyal American Medicare Supplement plan.

These application need to be reviewed and signed by an Agent before they can be submitted to Loyal American . You may email, fax or mail it in to CDA Insurance:

- Fax: 1.888.632.5470 or 1.541.284.2994
- Email: dann@lowinsure.com
- Mail: CDA Insurance LLC
2160 W 11th Ave
Eugene, Oregon 97402

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

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



SECTION IV – OPEN ENROLLMENT/GUARANTEED ISSUE QUESTIONS (MUST BE COMPLETED)

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".)

	YES	NO
To the best of your knowledge,		
1. (a) Did you turn age 65 in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Did you enroll in Medicare Part B in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
If "YES", what is the effective date? _____.		
2. Are you covered for medical assistance through the state Medicaid program?	<input type="checkbox"/>	<input type="checkbox"/>
(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.)		
If "YES":		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
If "YES"		
(a) Fill in your START and END dates below. If you are still covered under this plan, leave "END" date 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?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Was this your first time in this type of Medicare plan?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?	<input type="checkbox"/>	<input type="checkbox"/>
4. (a) Do you have another Medicare supplement policy in force?	<input type="checkbox"/>	<input type="checkbox"/>
(b) If so, with what company and what type plan do you have? _____		

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
(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" date blank. START ____/____/____ END ____/____/____		

SECTION V – MEDICARE

	YES	NO
1. Do you now have Medicare Parts A and B?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, give effective date of Part B: _____		
2. 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.

SECTION VI - MEDICAL QUESTIONS

**IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEE ISSUE
(BASED ON YOUR ANSWERS IN SECTION IV), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.**

If the answer to any question in this section is YES the Applicant is not eligible for coverage.

- | | | |
|---|--------------------------|--------------------------|
| 1. Are you currently confined or scheduled for admission to a hospital, nursing facility, or assisted living facility, or are you receiving home health care services? | 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? | | |
| b. Been confined to a nursing facility for more than 30 days? | | |
| 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, Peripheral Vascular Disease, Bypass, Endarterectomy, Carotid Artery Disease, Coronary Artery Disease or Heart Disease? | | |
| d. Had a Stroke or Transient Ischemic Attack (TIA)?..... | | |
| | | |
| 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? | | |
| b. Major Depression, Bi-Polar Disorder, Schizophrenia or a Paranoid Disorder? | | |
| c. Insulin Dependent Diabetes, Diabetes with Neuropathy, Retinopathy or Vascular Disease; Chronic Kidney Disease, Addison's Disease, Renal Insufficiency, Renal Failure, or any Kidney Disease requiring dialysis, or any condition requiring an organ transplant? | | |
| d. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease or Lymphoma? | | |
| e. Alcohol or Drug Abuse? | | |
| f. Paralysis, Hemophilia, Osteoporosis with fractures, or un-repaired Aneurysm? | | |
| g. Paget's Disease, Rheumatoid or Disabling Arthritis, Lupus or other Connective tissue disorder? | | |
| 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 (Lou Gehrig's Disease), Muscular Dystrophy, Cerebral Palsy, Dementia, Senility, Alzheimer's Disease or Organic Brain Disorder? | | |
| 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 Lung or respiratory disorder requiring the use of oxygen? | | |
| d. Amputation caused by disease or organ transplant other than corneas? | | |
| | | |
| 7. Do you have now, or in the last three (3) years have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for Anemia requiring repeated blood transfusions, any other blood disorder, or disorder of the pancreas? | | |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has surgery been advised but not performed or any surgery anticipated, including cataract surgery? | | |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have medical tests, treatment, or therapy been advised but not performed?..... | | |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Please list any prescription or any over-the-counter medications you have taken within the past 12 months. | | |

Medication	Dates Taken	Condition Taken For

NOTE: Please attach a separate sheet if needed.

SECTION VII - COMMENTS

SECTION VIII – IMPORTANT STATEMENTS FOR APPLICANT TO READ

- You do not need more than one Medicare supplement policy.
- If you purchase 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 as a 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”) for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) No agent has the authority to waive the answer to any questions on the application; (2) no insurance will be effective until a policy has been issued by the Company; and (3) I have received the Outline of Medicare Supplement Coverage for the policy applied for and the required *Guide to Health Insurance for People with Medicare*.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to the fines and confinement in prison.

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

A recorded telephone interview may be used as part of the underwriting on your application for insurance.

Telephone Number: () _____

Best Time to Call: _____

Applicant's Printed Name

Signature of Applicant

Date

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

LOYAL AMERICAN LIFE INSURANCE COMPANY - P. O. Box 559015 – Austin, TX 78755-9015

MEDICARE SUPPLEMENT SUPPLEMENTARY APPLICATION

Definitions of Eligible Person for Guaranteed Issue

An eligible person is an individual described in any of the following paragraphs:

- (1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.
- (2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:
 - (A) The certification of the organization or plan has been terminated; or
 - (B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
 - (C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;
 - (D) The individual demonstrates, in accordance with guidelines established by the Secretary, that:
 - (i) The organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or
 - (ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
 - (E) The individual meets such other exceptional conditions as the Secretary may provide.
- (3) The individual is enrolled with an entity listed in subparagraphs (A) - (D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) of this subsection:

- (A) An eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost);
 - (B) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
 - (C) An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
 - (D) An organization under a Medicare Select policy; and
- (4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
- (A) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of other involuntary termination of coverage or enrollment under the policy;
 - (B) The issuer of the policy substantially violated a material provision of the policy; or
 - (C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;
- (5) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or
- (6) The individual, upon first becoming enrolled in Medicare part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.
- (7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.
- (8) The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

If any of the definitions apply to you, please complete an Application for Medicare Supplement Insurance and submit evidence of the date of termination or disenrollment. Application must be made for coverage no later than 63 days of termination or disenrollment.

I acknowledge receipt of this Supplementary Application.

Signature of Applicant

Date

**MEDICARE SUPPLEMENT INSURANCE PRE-AUTHORIZATION AGREEMENT
FOR ELECTRONIC FUNDS TRANSFER APPLIES TO**

(must select one below):

LOYAL AMERICAN LIFE 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

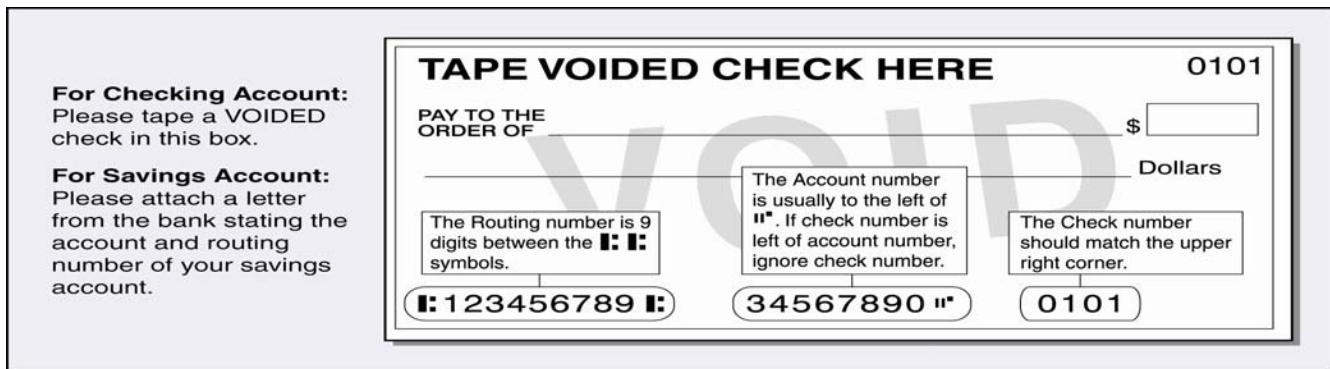
Type of Account:

- 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



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.

Name of Payor (if other than Insured) _____ Payor's Address _____

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



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

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

1. The Company, as used in this authorization, shall mean:

<input type="checkbox"/> Great American Life Insurance Company®	<input checked="" type="checkbox"/> Loyal American Life Insurance Company®
<input type="checkbox"/> United Teacher Associates Insurance Company	<input type="checkbox"/> Central Reserve Life Insurance Company
<input type="checkbox"/> Provident American Life & Health Insurance Company	<input type="checkbox"/> Continental General 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, Texas 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 to 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):

LOYAL AMERICAN LIFE 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):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient 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 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

Dann Loewenthal - PO Box 26540, Eugene, OR 97402

Type or Print Name and Address of Agent or Broker

Applicant's Signature

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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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):

- Additional benefits.
- My plan has outpatient drug coverage and I am enrolling in Part D.
- No change in benefits, but lower premiums.
- Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment. _____
- Fewer benefits and lower premiums.
- 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

Dann Loewenthal - PO Box 26540, Eugene, OR 97402

Type or Print Name and Address of Agent or Broker

Applicant's Signature

Date