

Thank you for your interest in applying for the Gerber Life Medicare Supplement plan!

This application needs to be reviewed and signed by an Agent before it can be submitted to Gerber Life. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: [dann@lowinsure.com](mailto:dann@lowinsure.com)
- Mail: CDA Insurance LLC  
2160 W 11<sup>th</sup> Ave  
Eugene, Oregon 97402

|  |
|--|
| Other Important Information  |
| Download Medicare's <a href="#">Choosing a Medigap Policy Guide</a> (.pdf) |
| Download <a href="#">Policy Outline</a> (.pdf)                             |

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

**Producer Name** \_\_\_\_\_ **Agent Writing Number or Social Security Number** \_\_\_\_\_ **Commission Share** \_\_\_\_\_ **Commission Code**- Required only if you are not appointed or licensed or are changing brokerage firms



|   |   |   |   |   |   |   |  |  |  |  |   |  |  |
|---|---|---|---|---|---|---|--|--|--|--|---|--|--|
| 0 | 3 | 0 | 1 | 6 | 7 | 2 |  |  |  |  | % |  |  |
|   |   |   |   |   |   |   |  |  |  |  | % |  |  |

**Note:** Producers must be under the same commission code to share or split commissions.

**Application Submission Checklist – Gerber Medicare Supplement Coverage**

- Provide Applicant with the Guide to Health Insurance for People with Medicare
- Provide Applicant with the Outline of Coverage
  - Calculate the premium based on age at application date
- Complete the Calculate Your Premium form (T03\_626) to determine rate
- Application (complete in full)
  - Sections A & B: Plan and Applicant Information**
    - Select plan
    - Enter Requested Effective Date
    - Indicate where the policy is to be mailed
  - Section C: Medicare Information**
    - Include applicant’s Medicare claim number on the application. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate “eligibility” and “enrollment” dates.
  - Section D: Previous or Existing Coverage Information**
    - Please complete ALL questions in full

**For Sections E and F – Refer to the Open Enrollment/Guaranteed Issue worksheet (T03\_633) to help identify eligibility.**

- Section E: Please answer all of the following questions**
  - If either Applicant A or B answered “YES” to question 5 OR BOTH questions 6 and 7 in Section E, they can skip to Section H
- Sections F & G: Health/Medication Information**
  - Do NOT answer if applicant is in an open enrollment or guaranteed issue period
- Section H: Agreement and Authorization**
  - Make sure applicant(s) sign and date the application
- Section J: To be Completed by Producer**
  - Make sure producer(s) sign and date the application
- Complete the Method of Payment form (T03\_635) and return with the completed application
  - Use premium determined by the Calculate Your Premium form (T03\_626)
  - The full modal premium is collected at the time of application
- Complete Replacement Notice (T03\_202) and leave a copy with the applicant (if applicable)
- Provide Applicant with Premium Receipt signed by agent (if applicable), and provide Applicant with Notice of Information Practices (T03\_364)

**Note:** An interviewer may call to verify/confirm the information provided on the application. This form is required if splitting commissions.



## Open Enrollment and Guaranteed Issue Worksheet

**If any of the following situations apply, applicant is in an open enrollment or guaranteed issue period:** (Situations may vary by state and coverage may be limited. Please refer to the Underwriting Guide for more information.)

### ELIGIBILITY FOR OPEN ENROLLMENT

#### Applicant is:

- at least 64 ½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

**Note: Coverage cannot be effective until your Medicare coverage is effective.**

### ELIGIBILITY FOR GUARANTEED ISSUE

**Evidence of eligibility is required for the following situations.**

#### Applicant:



- is in the original Medicare plan, has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending
- is in the original Medicare plan, has a Medicare Select policy, and moves out of the Select plan's service area
- loses coverage due to their Medicare supplement insurance company's insolvency or at no fault of the applicant
- the applicant leaves their Medicare supplement plan because the company has not followed rules, or has misled the applicant

*Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.*

#### Applicant was enrolled in a Medicare Advantage (MA) plan, and:

- the plan is leaving the Medicare program or stops service in the applicant's area, or the applicant moves out of the plan's service area (applicant must switch back to original Medicare)
- the applicant leaves the plan because the company has not followed rules, or has misled the applicant

*Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.*

- the applicant decided to switch to original Medicare within the first year of joining a MA plan when first eligible for Medicare Part A at age 65

*Applicant has the right to buy any Medicare supplement plan that is sold in the applicant's state by any insurance company.*

- after dropping their Medicare supplement policy to join a MA plan for the first time, has been on the MA plan less than one year and wants to switch back

*Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available, buy any Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.*

#### Acceptable Evidence of Eligibility:

- a. Copy of the applicant's MA plan's termination notice
- b. Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
- c. Signed statement that the applicant has requested to be disenrolled from his/her MA plan
- d. Certification of group coverage
- e. Copy of the termination letter from employer or group carrier
- f. Image of insurance ID card (ONLY allowed if your MA plan is being terminated)



# Height and Weight Chart

## Eligibility

Find your height in the left-hand column and look across the row to find your weight. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time.

|        | <b>Decline</b> | <b>Standard</b> | <b>Decline</b> |
|--------|----------------|-----------------|----------------|
| Height | Weight         | Weight          | Weight         |
| 4' 2"  | < 54           | 54 – 145        | 146 +          |
| 4' 3"  | < 56           | 56 – 151        | 152 +          |
| 4' 4"  | < 58           | 58 – 157        | 158 +          |
| 4' 5"  | < 60           | 60 – 163        | 164 +          |
| 4' 6"  | < 63           | 63 – 170        | 171 +          |
| 4' 7"  | < 65           | 65 – 176        | 177 +          |
| 4' 8"  | < 67           | 67 – 182        | 183 +          |
| 4' 9"  | < 70           | 70 – 189        | 190 +          |
| 4' 10" | < 72           | 72 – 196        | 197 +          |
| 4' 11" | < 75           | 75 – 202        | 203 +          |
| 5' 0"  | < 77           | 77 – 209        | 210 +          |
| 5' 1"  | < 80           | 80 – 216        | 217 +          |
| 5' 2"  | < 83           | 83 – 224        | 225 +          |
| 5' 3"  | < 85           | 85 – 231        | 232 +          |
| 5' 4"  | < 88           | 88 – 238        | 239 +          |
| 5' 5"  | < 91           | 91 – 246        | 247 +          |
| 5' 6"  | < 93           | 93 – 254        | 255 +          |
| 5' 7"  | < 96           | 96 – 261        | 262 +          |
| 5' 8"  | < 99           | 99 – 269        | 270 +          |
| 5' 9"  | < 102          | 102 – 277       | 278 +          |
| 5' 10" | < 105          | 105 – 285       | 286 +          |
| 5' 11" | < 108          | 108 – 293       | 294 +          |
| 6' 0"  | < 111          | 111 – 302       | 303 +          |
| 6' 1"  | < 114          | 114 – 310       | 311 +          |
| 6' 2"  | < 117          | 117 – 319       | 320 +          |
| 6' 3"  | < 121          | 121 – 328       | 329 +          |
| 6' 4"  | < 124          | 124 – 336       | 337 +          |
| 6' 5"  | < 127          | 127 – 345       | 346 +          |
| 6' 6"  | < 130          | 130 – 354       | 355 +          |
| 6' 7"  | < 134          | 134 – 363       | 364 +          |
| 6' 8"  | < 137          | 137 – 373       | 374 +          |
| 6' 9"  | < 140          | 140 – 382       | 383 +          |
| 6' 10" | < 144          | 144 – 392       | 393 +          |
| 6' 11" | < 147          | 147 – 401       | 402 +          |
| 7' 0"  | < 151          | 151 – 411       | 412 +          |
| 7' 1"  | < 155          | 155 – 421       | 422 +          |
| 7' 2"  | < 158          | 158 – 431       | 432 +          |
| 7' 3"  | < 162          | 162 – 441       | 442 +          |
| 7' 4"  | < 166          | 166 – 451       | 452 +          |

Medicare supplement insurance is underwritten by  
**Gerber Life Insurance Company**

Administrative Office  
 P.O. Box 2271  
 Omaha, Nebraska 68103-2271



Agent Writing #

FAV Key



**Gerber Life  
Insurance Company**



### Application for Medicare Supplement Coverage

Applicant acknowledges and agrees that if there is more than one applicant on this application, all information provided may be viewed or shared with the other applicant.

### A. Plan Information (to be completed by Producer)

| Applicant A   | Applicant B   |
|---|---|
| Plan (select one) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G | Plan (select one) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G |
| Requested Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/>                       | Requested Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/>                       |
| Deliver Policy to<br>Applicant A <input type="checkbox"/> Producer <input type="checkbox"/>                       | Deliver Policy to<br>Applicant B <input type="checkbox"/> Producer <input type="checkbox"/>                       |

### B. Applicant Information

| Applicant A   | Applicant B   |
|---|---|
| Name (First/Middle/Last)  | Name (First/Middle/Last)  |
| Residence Address   | Residence Address   |
| City  | City  |
| State <span style="float: right;">ZIP</span>  | State <span style="float: right;">ZIP</span>  |
| Mailing Address (if different from residence address)   | Mailing Address (if different from residence address)   |
| City  | City  |
| State <span style="float: right;">ZIP <input type="text"/></span>                             | State <span style="float: right;">ZIP <input type="text"/></span>                             |
| Home Phone <input type="text"/> - <input type="text"/> - <input type="text"/><br>(area code)  | Home Phone <input type="text"/> - <input type="text"/> - <input type="text"/><br>(area code)  |
| E-mail Address  | E-mail Address  |
| Current Age _____   | Current Age _____   |
| Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/><br>mo day yr | Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/><br>mo day yr |
| <input type="checkbox"/> Male <input type="checkbox"/> Female                                 | <input type="checkbox"/> Male <input type="checkbox"/> Female                                 |
| Social Security # <input type="text"/> - <input type="text"/> - <input type="text"/>          | Social Security # <input type="text"/> - <input type="text"/> - <input type="text"/>          |

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## B. Applicant Information (continued)

### Applicant A

|  |  |
|--|--|
| Height<br>Ft <input type="text"/> <input type="text"/> In <input type="text"/> <input type="text"/>                  | Weight<br>Lbs <input type="text"/> <input type="text"/> <input type="text"/> |
| Have you used tobacco in any form in the past 12 months? ..... <input type="checkbox"/> Y <input type="checkbox"/> N |  |

### Applicant B

|  |  |
|--|--|
| Height<br>Ft <input type="text"/> <input type="text"/> In <input type="text"/> <input type="text"/>                  | Weight<br>Lbs <input type="text"/> <input type="text"/> <input type="text"/> |
| Have you used tobacco in any form in the past 12 months? ..... <input type="checkbox"/> Y <input type="checkbox"/> N |  |



## C. Medicare Information

Please reference your Medicare card to complete this section.

|  |  |
|--|--|
| <b>MEDICARE</b> <b>HEALTH INSURANCE</b><br>1-800-MEDICARE (1-800-633-4227) |  |
| NAME OF BENEFICIARY<br>JANE DOE  |  |
| MEDICARE CLAIM NUMBER<br>000-00-0000-A                                     | SEX<br>FEMALE                              |
| IS ENTITLED TO<br>HOSPITAL (PART A)<br>MEDICAL (PART B)                    | EFFECTIVE DATE<br>07-01-2010<br>07-01-2010 |

### Applicant A

|   |
|---|
| Medicare Claim Number   |
| Medicare Part A Effective Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>   |
| If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>        |
| Medicare Part B Effective Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>   |
| If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> |

### Applicant B

|   |
|---|
| Medicare Claim Number   |
| Medicare Part A Effective Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>   |
| If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>        |
| Medicare Part B Effective Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>   |
| If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> |

## D. Previous or Existing Coverage 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 certificate, or that you had certain rights to buy such a policy or certificate, 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" with an "X" to the questions below.

| To the Best of Your Knowledge and Belief:  | Applicant A   | Applicant B   |
|--|---|---|
| 1. Are you covered for medical assistance through the state Medicaid program?.....<br>(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.)<br><b>If "YES," answer the following about this existing coverage:</b> | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| (a) Will Medicaid pay your premiums for this Medicare supplement policy?.....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |

### Please answer questions regarding another Medicare supplement or Select plan:

|  |   |   |
|--|---|---|
| 2. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?..... | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <b>If "YES," answer the following about this existing coverage:</b>  |   |   |
| (a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....      | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| (b) Indicate planned termination or disenrollment date.....  | Applicant A   | Applicant B   |
|  | ____/____/____  | ____/____/____  |
| (c) With what company, and what plan do you have?  |   |   |

| Applicant A     | Applicant B     |
|-----------------|-----------------|
| Name of Company | Name of Company |
| Plan            | Plan            |

### Please answer questions regarding Medicare plan coverage (other than Medicare supplement):

|  | Applicant A   | Applicant B   |
|--|---|---|
| 3. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)..... | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <b>If "YES," answer the following about this previous or existing coverage:</b>  |   |   |
| (a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.....   | Applicant A   | Applicant B   |
| START  | ____/____/____  | ____/____/____  |
| END  | ____/____/____  | ____/____/____  |
| Applicant B  | 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"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| (c) Planned date of termination/disenrollment?.....  | Applicant A   | Applicant B   |
|  | ____/____/____  | ____/____/____  |
| (d) Was this your first time in this type of Medicare plan?.....   | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| (e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....   | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| (f) Did you drop a union group or employer health plan to enroll in this Medicare plan?..  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |

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**If you are applying during an open enrollment or guaranteed issue period:  
SKIP SECTIONS F & G and GO TO SECTION H.**



**F. Health Information**

**For all plans, answer questions 8-16.**

(If "YES" is answered to any of the following questions 8-16, that person is not eligible for coverage.)

| To the Best of Your Knowledge and Belief:   | <b>Applicant A</b>                                    | <b>Applicant B</b>                                    |
|---|---|---|
| 8. Are you currently confined to a wheelchair or any motorized mobility device?.....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 9. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility where you receive skilled nursing care, or receiving any occupational or physical therapy? .....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 10. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing or any surgery that has not been performed? .....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 11. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:   |   |   |
| A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis? .....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?.....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| C. Alzheimer's Disease, dementia or any other cognitive disorder? .....   | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| D. Parkinson's Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?.....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| E. Systemic Lupus or Myasthenia Gravis? .....   | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| G. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)? .....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| H. Chronic hepatitis or cirrhosis? .....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| I. Osteoporosis with fractures? .....   | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 12. Do you have diabetes with complications including retinopathy, neuropathy, peripheral vascular disease, any related heart disorder (Including hypertension/high blood pressure) or kidney disease? .....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 13. Do you have an implanted cardiac defibrillator? .....   | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 14. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:   |   |   |
| A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement? .....   | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| B. Cardiomyopathy, Congestive Heart Failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?..... | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| C. Alcoholism or drug abuse? .....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist? .....   | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| E. Internal cancer, lymphoma or melanoma? .....   | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| F. A stroke or transient ischemic attack (TIA)? .....   | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?...  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 15. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts? .....   | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 16. Have you been hospital confined three or more times in the past two years for a same or similar condition? .....  | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |

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## G. Medication Information



If you are applying OUTSIDE of an open enrollment or guaranteed issue period, please list all over-the-counter or prescription medications you have taken in the past 24 months in the table below.

### Applicant A

| Medication Name<br>(copy off pharmacy label) | Dosage | Frequency | Have you taken<br>this medication for<br>more than 2 years? | Prescribed<br>by Primary<br>Physician?                | Diagnosis/Condition |
|--|--------|-----------|---|---|---------------------|
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |

### Applicant B

| Medication Name<br>(copy off pharmacy label) | Dosage | Frequency | Have you taken<br>this medication for<br>more than 2 years? | Prescribed<br>by Primary<br>Physician?                | Diagnosis/Condition |
|--|--------|-----------|---|---|---------------------|
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |
|  |        |           | <input type="checkbox"/> Y <input type="checkbox"/> N       | <input type="checkbox"/> Y <input type="checkbox"/> N |                     |

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**Part I. Select Premium Payment Option**

|  |   |   |
|--|---|---|
| <p><b>Initial Premium (Select option #1 or #2)</b><br/>                 Initial premium amount (based on age at application date and includes one-time application fee in applicable states)....<br/>                 1. Paper Check (submit signed check with application).....<br/>                 2. Automated Bank Account Withdrawal.....</p> <p><b>Ongoing Premium Payments (Select option #1 or #2)</b><br/>                 1. I want my payments automatically withdrawn from my bank account every month on (Circle date).....<br/>                 2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing).....</p> | <p><b>Applicant A</b></p> <p>\$ _____</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p>1<sup>st</sup> or 15<sup>th</sup></p> <p>every _____ months<br/>Insert 3, 6, or 12</p> | <p><b>Applicant B</b></p> <p>\$ _____</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p>1<sup>st</sup> or 15<sup>th</sup></p> <p>every _____ months<br/>Insert 3, 6, or 12</p> |
|--|---|---|

**Part II. Payor Information**

|   |  |  |
|---|--|--|
| <p><b>Complete the following if premium is NOT paid by applicant (includes spouse or joint-married account):</b></p> <p>1. <b>Account Owner Name</b>, if different than applicant's.....<br/>                 2. <b>Account Owner Relationship</b> to applicant:</p> <p style="text-align: right;">Living Trust <input type="checkbox"/></p> <p style="text-align: right;">Power of Attorney or legal guardian (documentation required) <input type="checkbox"/></p> <p style="text-align: right;">Business owned by applicant or applicant's spouse <input type="checkbox"/></p> | <p><b>Applicant A</b></p> <p>_____</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> | <p><b>Applicant B</b></p> <p>_____</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> |
|---|--|--|

**Part III. Account Information**

**Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:**  
 This section is intended as authorization to debit your bank account.  
 Complete bank account information below **OR** attach a copy of a voided check (Do NOT use a deposit slip)

|  |   |
|--|---|
| <p><b>Applicant A</b></p> <p>Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings</p> <p>_____<br/>Name of Financial Institution</p> <p>_____<br/>Routing Number (9 digits on lower left side of check)</p> <p>_____<br/>Account Number (Do NOT use Debit/Credit Card numbers)</p> <p>_____<br/>Name as Shown on Account</p> | <p><b>Applicant B</b> <input type="checkbox"/> Same account as Applicant A</p> <p>Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings</p> <p>_____<br/>Name of Financial Institution</p> <p>_____<br/>Routing Number (9 digits on lower left side of check)</p> <p>_____<br/>Account Number (Do NOT use Debit/Credit Card numbers)</p> <p>_____<br/>Name as Shown on Account</p> |
|--|---|

**Can attach voided check here**

- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.



**Example:**

|   |  |
|---|--|
| Account Holder Name                               | Do NOT include the check # in the Routing or Account Number. |
| John Doe<br>Street Address<br>Town, City ZIP Code | Check #1234<br>Date: _____                                   |
| Pay to: _____                                     |  |
| Routing/Transfer Number                           | Account Number Dollars                                       |
| Financial Institution Name & Address              |  |
| Memo: _____ Signed By: _____                      |  |
| ⑆123456789⑆ 12345678 ⑆ 1234 ⑆                     |  |

**IMPORTANT: When choosing to pay initial premium by Automated Bank Account Withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY. The first withdrawal date may be different from the monthly date selected for renewal premiums.**

I authorize Gerber Life Insurance Company to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account to Gerber Life Insurance Company any preauthorized electronic fund transfers. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

|  |  |
|--|--|
| <p></p> <p>Authorized Signature as Shown on Account</p> <p>_____</p> <p>Date</p> | <p></p> <p>Authorized Signature as Shown on Account</p> <p>_____</p> <p>Date</p> |
|--|--|

# GERBER LIFE INSURANCE COMPANY

Administrative Office  
P.O. Box 2271  
Omaha, Nebraska 68103-2271

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## Initial Premiums Paid through Automated Bank Account Withdrawal

Medicare supplement applications may have their initial premiums automatically deducted from their checking or savings account through a specific Electronic Funds Transfer (EFT) process identified as Automated Bank Account Withdrawal. When they do, you may fax the application and required forms instead of mailing them.

Follow these easy steps to submit Med supp apps using Automated Bank Account Withdrawal for initial premiums:

### Step 1 - Complete the **Method of Payment** form

For applicants wishing to pay electronically for either their **initial** or **renewal** premium(s), complete the entire Med supp *Method of Payment* form (T03\_635), included in the application package:

### Step 2 - Fax the following items included in the application package to the dedicated line for Automated Bank Account Withdrawal payments at 1-866-422-9139

1. Automated Bank Account Withdrawal fax transmittal cover sheet on the back of this form, T03\_627
2. Med supp *Method of Payment* form, T03\_635
3. Med supp application and other required forms

### Tips for Submitting Initial Premiums through Automated Bank Account Withdrawal

- Do not send a signed check for the initial premium; clients could be charged twice
- Do not fax the forms more than once; additional charges could result
- If you fax the forms, do not mail them, too; processing errors occur and additional charges result

For producer use only. Not for use with the general public.

P.O. Box 2271  
Omaha, NE 68103-2271



**Gerber Life  
Insurance Company**

Call 1-877-617-5592  
Fax 1-866-422-9139

## Fax

### Use to Transmit Applications with Initial Payment by Automated Bank Account Withdrawal 1-866-422-9139\*

\*Use this fax number only for applications and new-business documents. Applications faxed to any other number can cause processing delays.

Please complete the following information:

Total number of pages being faxed (including this cover sheet) \_\_\_\_\_

|               |                        |
|---------------|------------------------|
| Producer Name | Producer Number or SSN |
| Phone Number  | Fax Number             |
| 541.434.9613  | 541.284.2994           |

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This communication and any attachments transmitted with it are confidential and are solely for the use of the addressee. It may contain material that is legally privileged, proprietary or subject to copyright belonging to Gerber Life Insurance Company and its affiliates, and it may be subject to protection under federal or state law. If you are not the intended recipient, you are notified that any use of this material is strictly prohibited. If you received this transmission in error, please contact the sender immediately by telephone, collect calls accepted, at the number shown above. We will arrange for you to return the original material to us via the U.S. Postal Service, and if requested, we will reimburse you for such expense.

T03\_627

**Gerber Life  
Insurance Company**

**Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage**

**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 Gerber 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.

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 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, Broker or Other Representative:**

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 reason(s) (check one):

| <b>Applicant</b>   | <b>Applicant B</b>   |
|--|--|
| <input type="checkbox"/> Additional benefits   | <input type="checkbox"/> Additional benefits   |
| <input type="checkbox"/> No change in benefits, but lower premiums   | <input type="checkbox"/> No change in benefits, but lower premiums   |
| <input type="checkbox"/> Fewer benefits and lower premiums   | <input type="checkbox"/> Fewer benefits and lower premiums   |
| <input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D          | <input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D          |
| <input type="checkbox"/> Disenrollment from a Medicare Advantage Plan<br>Please explain reason for disenrollment | <input type="checkbox"/> Disenrollment from a Medicare Advantage Plan<br>Please explain reason for disenrollment |
| <input type="checkbox"/> Other (please specify)<br>_____<br>_____  | <input type="checkbox"/> Other (please specify)<br>_____<br>_____  |

If you still wish to terminate your present policy or certificate 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 or certificate until you have received your new policy and are sure that you want to keep it.



\_\_\_\_\_  
**Signature of Agent, Broker or Other Representative**

\_\_\_\_\_  
**Date**

Gerber Life Insurance Company, P.O. Box 2271, Omaha, Nebraska 68103-2271

| <b>Applicant</b> | <b>Applicant B</b> |
|------------------|--------------------|
| Signature        | Signature          |
| Date             | Date               |



T03\_202

## IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and client notifications on the following pages are to be given to the applicant(s) if applicable.

**Replacement Notice**

If replacing, both you and the applicant must sign the customer copy of the replacement notice.

**Premium Receipt / Notice of Information Practices**



**Gerber Life  
Insurance Company**

**Notice to Applicant Regarding Replacement of Medicare Supplement Insurance  
or Medicare Advantage**

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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 Gerber 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.

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 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, Broker or Other Representative:**

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| <b>Applicant</b>   | <b>Applicant B</b>   |
|--|--|
| <input type="checkbox"/> Additional benefits   | <input type="checkbox"/> Additional benefits   |
| <input type="checkbox"/> No change in benefits, but lower premiums   | <input type="checkbox"/> No change in benefits, but lower premiums   |
| <input type="checkbox"/> Fewer benefits and lower premiums   | <input type="checkbox"/> Fewer benefits and lower premiums   |
| <input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D          | <input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D          |
| <input type="checkbox"/> Disenrollment from a Medicare Advantage Plan<br>Please explain reason for disenrollment | <input type="checkbox"/> Disenrollment from a Medicare Advantage Plan<br>Please explain reason for disenrollment |
| <input type="checkbox"/> Other (please specify)<br>_____<br>_____  | <input type="checkbox"/> Other (please specify)<br>_____<br>_____  |

If you still wish to terminate your present policy or certificate 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 or certificate until you have received your new policy and are sure that you want to keep it.



\_\_\_\_\_  
**Signature of Agent, Broker or Other Representative**

\_\_\_\_\_  
**Date**

Gerber Life Insurance Company, P.O. Box 2271, Omaha, Nebraska 68103-2271

| <b>Applicant</b> | <b>Applicant B</b> |
|------------------|--------------------|
| Signature        | Signature          |
| Date             | Date               |



**Gerber Life  
Insurance Company**

**Premium Receipt**

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All premiums must be made payable to Gerber Life Insurance Company.

**Do not make check payable to the agent or leave the payee blank.**

**Applicant A**

Received from \_\_\_\_\_  
this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
an application for Form \_\_\_\_\_ Policy  
and/or Riders \_\_\_\_\_ and \_\_\_\_\_  
Check for \_\_\_\_\_ Dollars.

**Applicant B**

Received from \_\_\_\_\_  
this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
an application for Form \_\_\_\_\_ Policy  
and/or Riders \_\_\_\_\_ and \_\_\_\_\_  
Check for \_\_\_\_\_ Dollars.

 Agent \_\_\_\_\_

 Agent \_\_\_\_\_

**No insurance of any kind shall take effect until a policy is issued and delivered to the applicant, and the initial premium is paid, all during the life of the applicant. If no policy is issued, Gerber Life Insurance Company shall have no liability except to refund the initial premium to the applicant. This is a receipt of your application and initial premium.**



**Notice of Information Practices**

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In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: GERBER LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, P.O. BOX 2271, OMAHA, NE 68103-2271.**

**Provide the completed premium receipt, if applicable, and notice to the applicant.**