MEDICARE SUPPLEMENT INSURANCE APPLICATION TO

— CONTINENTAL GENERAL INSURANCE COMPANY —

8901 Indian Hills Drive — P.O. Box 247007 — Omaha, NE. 68124-7007

1. Name of Proposed Insured (Print) Last First Initial	Sex	Birthdate Mo. Day Year	Age	Social Security No.

Resident Street Address (No P.O. Box)	City	State	Zip	Telephone No.
Billing Address	City	State	Zip	Telephone No.

COVERAGE APPLIED FOR:

Check plan selected:

☐ Plan A
☐ Plan B
☐ Plan C
☐ Plan D
☐ Plan F
☐ Plan G
☐ Plan F* (High Ded.)

Check premium payment mode selected:

☐ Annual
☐ Semi-Annual
☐ Quarterly
☐ Monthly BOM
☐ Monthly (Direct)

Amount of Premium Submitted with the Application: $ _______________

To the best of your knowledge,

1. Ever used tobacco in any form within the last 12 months? ☐ Yes ☐ No

OPEN ENROLLMENT — STATE LAW REQUIRES THAT A 6-MONTH OPEN ENROLLMENT PERIOD BE PROVIDED TO AN APPLICANT WHEN FIRST ENROLLING IN MEDICARE PART B. IF APPLICANT QUALIFIES FOR OPEN ENROLLMENT, AS DEFINED; OR IF THE APPLICANT IS AN "ELIGIBLE PERSON" AS DEFINED IN FORM MSUPP-GI (PA), DO NOT ANSWER QUESTION 2.

2. If the answer to any of the questions in this section is 'yes', the proposed insured is not eligible for coverage.

		Yes	No
a.	Are you currently confined in a hospital or within the past 2 years, have you been hospitalized more than three times or confined to a nursing facility?	☐	☐
b.	Has surgery been medically advised but not performed or is surgery anticipated?	☐	☐
c.	Are you bedridden; confined to a wheelchair; or during the past two years have you had any type of amputation caused by disease?	☐	☐
d.	Do you have Emphysema or Chronic Obstruction Pulmonary Disease (COPD)?	☐	☐
e.	Within the past 2 years, have you been medically treated for internal cancer, melanoma, Parkinson's Disease, multiple sclerosis, muscular dystrophy, heart valve surgery, cirrhosis of the liver, stroke, transient ischemic attack, Alzheimer's Disease, senile dementia, organic brain disorder, or other senility disorder, or are you an insulin-dependent diabetic?	☐	☐
f.	Have you been medically advised to have kidney dialysis?	☐	☐

- 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.
- 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 policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.
- 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 a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

3. Do you have another Medicare supplement policy or certificate inforce? ☐ Yes ☐ No
   a. If so, with which company? _______________
   b. Effective date of existing coverage _______________
   c. Do you intend to replace your current Medicare supplement policy with this policy (certificate)? ☐ Yes ☐ No
   d. Date this policy is to be terminated _______________

4. Do you have any other health insurance coverage inforce? ☐ Yes ☐ No
   a. If so, with which company? ____________________
   b. What kind of policy(s)____________________
   c. Effective date of other health coverage ____________
   d. Termination date of other health coverage ____________

5. Are you covered for medical assistance through the **State Medicaid** program? ☐ Yes ☐ No
   a. As a Specified Low-Income Medicare Beneficiary (SLMB)? ☐ Yes ☐ No
   b. As a Qualified Medicare Beneficiary (QMB)? ☐ Yes ☐ No
   c. For other Medicaid medical benefits? ☐ Yes ☐ No

6. Do you now have Medicare Parts A and B? ☐ Yes ☐ No Medicare Card Number ____________
   If yes, give effective date of Part B: ____________ (The complete Health Insurance Claim Number — including the alpha letter(s) — shown on the applicant's Medicare Card.)

7. 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.

I have received the Outline of Coverage for the policy applied for and the required Guide to Health Insurance for People with Medicare . . . . ☐ YES ☐ NO

I apply to Continental General Insurance Company, Omaha, Nebraska, for insurance 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 physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health, to give to the Continental General Insurance Company, or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for 30 months.

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

DATED AT ____________ (City) (State) this ________ day of ____________ (Month) (Year)

X____________________
Signature of Applicant

AGENT'S CERTIFICATE

1. List the health policies you sold to this applicant which are still in force: (if this does not apply, state NONE).

____

____

2. (a) Have you reviewed the application for correctness and omissions? . . . . ☐ YES ☐ NO
   (b) Was application completed by you in applicant's presence? . . . . ☐ YES ☐ NO
   (c) Do you have knowledge or reason to believe the replacement of existing insurance may be involved? . . . . ☐ YES ☐ NO

If "YES" give Name of Company, reason and termination date ____________________

____

I certify that I saw the applicant and truly and accurately recorded, in the applicant's presence, all the information supplied me by the applicant.

Signature of Licensed Resident Agent ____________ (Print Name) / ____________ (Signature) # ________

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.

Form MA-PA

CONTINENTAL GENERAL INSURANCE COMPANY
8901 Indian Hills Drive • PO Box 247007 • Omaha,NE 68124-7007 • 402-397-3200

BANK AUTHORIZATION

CONTINENTAL GENERAL INSURANCE COMPANY is hereby requested and authorized to draw checks to be charged against the checking account of:

____
(print name as shown on bank records) (account number)

with ______________________________
(name of bank and branch name, if any) (transit no. #)

____
(address of bank or branch where account is maintained)

for the purpose of collecting premiums payable to CONTINENTAL GENERAL INSURANCE COMPANY under the bank check premium arrangement.The policy(ies) are to be placed under the bank check premium arrangement, upon approval by the Company, for premiums due.

It is understood that CONTINENTAL GENERAL INSURANCE COMPANY'S premium arrangement may be terminated by the policy owner or by the Company upon written notice.

(Date) ____________ ______________________
(signature of policy owner)

Authorization to honor checks drawn by Continental General Insurance Company, Omaha, Nebr.

to

______________ ______________
(name of bank depositor) (name of bank and branch name, if any)

______________ ______________
(account no.#) (address of bank or branch where account is maintained)

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn by Continental General Insurance Company to its own order. This authorization will 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 check.

I agree that your treatment of each such check, and your rights in respect to it, shall be the same as if it were signed personally by me. I further agree that if any such check be dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Continental General Insurance Company is instructed to forward this authorization to you.

__________ ______________________
date (signature of bank depositor—as shown on bank records for the account to which this authorization is applicable)

INDEMNIFICATION AGREEMENT

To: The Bank Named Above

In consideration of your participation in a plan which the CONTINENTAL GENERAL INSURANCE COMPANY has put in effect by which amounts for premiums due on policies of insurance are collected by drafts drawn by the company on the accounts of persons who have made themselves responsible for these payments, the Company does hereby agree that subject to the terms and provisions of such insurance policies without varying, extending or altering the terms, thereof:

(1) It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any check drawn by the Company on the account of such person, or arising out of the dishonor by you, whether with or without cause or intentionally or inadvertently, of any such check drawn by the Company, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture, of a policy of insurance the premium on which is sought to be collected by the Company by any such check; and

(2) It will refund to you any amount erroneously paid by you on any such check if claim for the amount of such erroneous payment is made by you within a reasonable time from the date of the check on which such erroneous payment was made.

____
(authorized Officer's signature) President

Please Note: A VOIDED check must accompany the authorization.

Application No.____________________

Applicant____________________________
(Please Print)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

CONTINENTAL GENERAL INSURANCE COMPANY
8901 Indian Hills Drive
P.O. Box 247007
Omaha, Nebraska 68124-7007

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

According to (your application or information you have furnished), you intend to lapse or otherwise terminate existing Medicare supplement insurance and replace it with a policy to be issued by Continental General Insurance Company. Federal and state law provides thirty days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing 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 coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY 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 coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason. (Check one):

________ Additional benefits.

________ No change in benefits, but lower premiums.

________ Fewer benefits and lower premiums.

________ Other (Please Specify).

____

____

____

(1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy 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/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, REREAD IT CAREFULLY TO BE CERTAIN THAT ALL INFORMATION HAS BEEN PROPERLY RECORDED.**

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

____

(Signature of Agent, Broker or Other Representative)

____

(Typed Name and Address of Agent or Broker)

The above "Notice to Applicant" was delivered to me on:

____

(Date)

____

(Applicant's Signature)

Plans A & B (Policy Forms 3AA & 3AB)
Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A Pays	You Pay	Plan B Pays	You Pay
Medical Expenses - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's Services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.					
First $100 of Medicare Approved Amounts*	$0	$0	$100	$0	$100
Remainder of Medicare Approved Amounts	80% (50% Outpatient Psychiatric Services)	20%(50% Outpatient Psychiatric Services)	$0	20%(50% Outpatient Psychiatric Services	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0	All Costs	$0	All Costs
Blood					
First 3 Pints	$0	3 Pints	$0	3 Pints	$0
Next $100 of Medicare Approved Amounts	$0	$0	$100	$0	$100
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
Clinical Laboratory Services - Blood Tests for Diagnostic Services	100%	$0	$0	$0	$0
Home Health Care Medicare Approved Services					
Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment					
First $100 of Medicare Approved Amounts*	$0	$0	$100	$0	$100
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
Foreign Travel - Not Covered by Medicare					
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA					
First $250 each calendar year	$0	$0	All Costs	$0	All Costs
Remainder of Charges	$0	$0	All Costs	$0	All Costs

Plans A, B, C & D (Policy Forms 3AA, 3AB, 3AC & 3AD)
Medicare (Part A) - Hospital Services - Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan A Pays	You Pay	Plan B Pays	You Pay	Plan C Pays	You Pay	Plan D Pays	You Pay
Hospitalization*									
Semiprivate room and board, general nursing and miscellaneous services and supplies									
First 60 days	All but $776	$0	$776	$776	$0	$776	$0	$776	$0
61st thru 90th day	All but $194 a day	$194 a day	$0	$194 a day	$0	$194 a day	$0	$194 a day	$0
91st day and after:									
-While using 60 lifetime reserve days	All but $388 a day	$388 a day	$0	$388 a day	$0	$388 a day	$0	$388 a day	$0
-Once lifetime reserve days are used:									
-Additional 365 days	$0	100% of eligible expenses	$0	100% of eligible expenses	$0	100% of eligible expenses	$0	100% of eligible expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs	$0	All Costs	$0	All Costs	$0	All Costs
Skilled Nursing Facility Care									
You must meet Medicare's requrements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital									
First 20 days	All approved amounts	$0	$0	$0	$0	$0	$0	$0	$0
21st thru 100th day	All but $97 a day	$0	Up to $97	$0	Up to $97	Up to $97	$0	Up to $97	$0
101st day and after	$0	$0	All Costs	$0	All Costs	$0	All Costs	$0	All Costs
Blood									
First 3 Pints	$0	3 Pints	$0	3 Pints	$0	3 Pints	$0	3 Pints	$0
Additional Amounts	100%	$0	$0	$0	$0	$0	$0	$0	$0
Hospice Care									
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance	$0	Balance	$0	Balance	$0	Balance

Plans C & D (Policy Forms 3AC & 3AD)
Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan C Pays	You Pay	Plan D Pays	You Pay
Medical Expenses - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's Services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.					
First $100 of Medicare Approved Amounts*	$0	$100	$0	$0	$100
Remainder of Medicare Approved Amounts	80% (50% Outpatient Psychiatric Services)	20%(50% Outpatient Psychiatric Services	$0	20%(50% Outpatient Psychiatric Services	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0	All Costs	$0	All Costs
Blood					
First 3 Pints	$0	3 Pints	$0	3 Pints	$0
Next $100 of Medicare Approved Amounts	$0	$100	$0	$0	$100
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
Clinical Laboratory Services - Blood Tests for Diagnostic Services	100%	$0	$0	$0	$0
Home Health Care Medicare Approved Services					
Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment					
First $100 of Medicare Approved Amounts*	$0	$100	$0	$0	$100
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
Foreign Travel - Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA					
First $250 each calendar year	$0	$0	$250	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over $50,000	80% to a lifetime maximum of $50,000	amounts over $50,000
At Home Recovery Services - Not Covered by Medicare Home care certified by your doctor for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan					
Benefit for each visit	$0	$0	All Costs	Actual Charges	
Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	$0	All Costs	Up to $40 a visit up to the number of Medicare approved visits not to exceed 7 each week	Balance
Calendar Year Maximum	$0	$0	All Costs	$1600	