Cigna Medicare Supplement Insurance
Loyal American Life Insurance Company

APPLICATION BOOKLET FOR

CALIFORNIA

This packet contains all required forms for application submission. Please complete each form according to the instructions on each page.

- Application
- Electronic funds transfer agreement
- MIB pre-notice
- HIPAA notices
- Replacement notice

Note: All Applications outside of OE/GI require a Phone Verification (PV) – Reduce delays and make the PV call at the point-of-sale. **Call our PV Hotline at 866.825.4822 from 8 a.m. to 6 p.m. Central Time**.

Together, all the way.®

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APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

LOYAL AMERICAN LIFE INSURANCE COMPANY®

11200 Lakeline Blvd., Suite 100, Austin, TX 78717 • Customer Service: 866-459-4272
Mailing address: PO Box 559015, Austin, TX 78755-9015

Application is for: ☐ New Business ☐ Underwritten (Medical History) ☐ Disabled (underage)
☐ Open Enrollment ☐ Guaranteed Issue ☐ Reinstatement ☐ Benefit Change

Requested Medicare Supplement Effective Date*: ____________ **Phone Verification Case #**____________
*note: if no Effective Date is requested, we will assign the 1st day of the month following the date of this Application

SECTION 1: APPLICANT INFORMATION (PLEASE PRINT)

Name of Applicant			Age	Date of Birth			State of Birth
First	MI	Last		MM	DD	YYYY	

Resident Street Address (no PO Box) ____________

City ____________ **State** ____________ **Zip** ____________

Mailing Address (if different from above) ____________

City ____________ **State** ____________ **Zip** ____________

Phone (   ) ____________ **Email Address** ____________

Medicare Card No.	Social Security No.	Sex M/F
	- -	

SECTION 2: COVERAGE APPLIED FOR

Check Plan selected: ☐ Plan A ☐ Plan F ☐ Plan G ☐ Plan N

SECTION 3: BILLING

Method (select one of the following):
☐ Direct Bill
☐ Bank Draft (complete the Electronic Funds Transfer Agreement)

Mode (select one of the following):
☐ Monthly (not available with Direct Bill)
☐ Quarterly
☐ Semi-annually
☐ Annually

SECTION 4: BILLING TOTALS

☐ Draft bank account for initial premium*
☐ Check enclosed for initial premium*
(make check payable to ***Loyal American Life Insurance Company)***

*initial premium payment must include the one-time enrollment fee

Modal Premium	$____________
One-time Enrollment Fee	$ 20
Total Premium with Application	$____________

SECTION 5: MEDICARE

	YES	NO	NOT SURE
1) Do You now have Medicare Parts A (hospital insurance) and B (medical insurance)?	☐	☐	☐

If YES, give effective date of Part B ________________________

2) If Medicare Parts A (hospital insurance) and B (medical insurance) 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 and B on the effective date of the policy. If not, coverage cannot be issued.

SECTION 6: OPEN ENROLLMENT / GUARANTEED ISSUE QUESTIONS (MUST BE COMPLETED)

OPEN ENROLLMENT

During Open Enrollment, You have the right to receive one of the required Medicare Supplement policies at the best prices for Your age, without medical underwriting (health screening).

Depending upon Your prior coverage, however, we may impose a waiting period before paying benefits for pre-existing conditions. (Pre-existing Condition(s): means a condition for which medical advice was given or treatment was recommended by or received from a Physician within six (6) months before the policy effective date.) The waiting period may last up to six (6)months prior to the date You bought the Plan.

We will not impose a waiting period if:

- You had health coverage during the six (6) months prior to applying for a Medicare Supplement plan;
- You are in a guaranteed-issue period; or
- You are buying a new Medicare Supplement policy to replace another one.

Please answer all questions regarding Open Enrollment eligibility to the best of Your knowledge.

A. If You Are Age 65 or Over

If You are age sixty-five (65) or over and eligible for Medicare, you have a six (6) month period during which you can purchase any Medicare Supplement policy at the lowest price for your age, even if you have or recently had health problems.

Your six (6)month Open Enrollment period starts the date your Medicare Part B coverage becomes effective.

Questions:

1) Did You turn age sixty-five (65) within the last six months?

Y or N

☐ ☐ **If YES, You may qualify for Open Enrollment. Skip to Section 8.**

2) Did You enroll in Medicare Part B, at age sixty-five (65) or older, within the last six (6) months?

Y or N

☐ ☐ **If YES, You may qualify for Open Enrollment. Skip to Section 8.**

3) Will Your Plan effective date be within six (6) months after turning age sixty-five (65) and enrolling in Medicare Part B?

Y or N

☐ ☐ **If YES, You may qualify for Open Enrollment. Skip to Section 8.**

B. If You Are Younger than Age 65

If You are younger than age sixty-five (65) and have Medicare because of a disability (except for End-Stage Renal Disease), You have Open Enrollment rights for six (6) months after the effective date of Your Medicare Part B coverage. If You are notified retroactively of Your eligibility for Medicare, Your Open Enrollment period begins from the date of the notice You receive from Social Security.

Questions:

1) Are You under age sixty-five (65) and have Medicare Part B coverage that has been effective for six (6) months or less?

Y or N

☐ ☐ **If YES, and You do not have End-Stage Renal Disease (ESRD), You may qualify for Open Enrollment. Skip to Section 8.**

2) Are You under age sixty-five (65) and received retroactive notice of your eligibility for Medicare within the past six (6) months?

Y or N

☐ ☐ **If YES, and You do not have End-Stage Renal Disease (ESRD), You may qualify for Open Enrollment. Skip to Section 8.**

C. Termination of Employment or Retirement Plan

You have the right to purchase a Medicare Supplement policy for six (6) months if You, Your spouse's or a family member's current employment or retirement plan coverage terminates, or You lose your eligibility due to divorce or death of a spouse or family member. The six (6) month period to apply for a Medicare Supplement policy starts on the date You receive notice that Your health benefits will end. If You do not receive advance notice, the six (6) month period starts the date the benefits end or the date of Your first denied claim. This right applies whether Your group health benefits were primary or secondary to Medicare. You are also entitled to this protection when You have used all the COBRA benefits to which You are entitled, unless You stop paying COBRA premiums before You use all your benefits.

Question:

1) Have You lost coverage by an employer-sponsored health plan within the last six (6) months?

Y or N

☐ ☐ **If YES, You may qualify for Open Enrollment. Skip to Section 8.**

D. Loss of Medi-Cal Benefits

You have the right to purchase a Medicare Supplement policy for six (6) months when You lose your eligibility for full benefits because of an increase in Your income or assets.

Question:

1) Have You lost your Medi-Cal within the last six (6) months due to an increase in Your income or assets?

Y or N

☐ ☐ **If YES, You may qualify for Open Enrollment. Skip to Section 8.**

E. Moving Out of the Medicare Supplement Plan's Service Area

You have the right to purchase a Medicare Supplement policy for six (6) months if You move out of the area served by Your Medicare Supplement plan. For example, if You bought a plan while living in another state that will not cover You in your current state, You have six (6) months to replace that plan.

Question:

1) Was Your Medicare Supplement coverage cancelled within the last six (6) months because Your residence changed to a location not serviced by Your plan?

Y or N

☐ ☐ **If YES, You may qualify for Open Enrollment. Skip to Section 8.**

F. Loss of Military Health Coverage

You have the right to purchase a Medicare Supplement policy for six (6) months if Your health care coverage ends because:

- a military base closes
- a military base no longer offers health care services
- You move away from a military base
- You lose access to health care services at a military base

Question:

1) Are You a military retiree or spouse of a retiree, and within the last six months were Your health care services cancelled due to a base closure, because the base no longer offers services, or because You relocated?

Y or N

☐ ☐ **If YES, You may qualify for Open Enrollment. Skip to Section 8.**

G. Annual 30-Day Period Starting on Your Birthday

You have the right to purchase certain Medicare Supplement plans each year for the thirty (30)-day period starting on Your birthday. You must have a current Medicare Supplement plan to exercise that right. You can choose a plan from any company, but You may be limited to one that has the same or fewer benefits than Your current plan. For example, if You already have Plan C, You may want to switch to another Plan C, but not to Plan G.

Question:

1) Are You enrolling during Your annual 30-day birthday Open Enrollment period that begins on Your birthday?

Y or N

☐ ☐ **If YES, and You are replacing a Medicare Supplement plan, You may qualify for Open Enrollment. Skip to Section 8.**

H. Medicare Advantage Plan Coverage Terminated
You have the right to an additional sixty (60) day Open Enrollment period to be added onto or after any Open Enrollment period authorized by federal law or regulation for any Medicare Supplement plan available on a Guaranteed Issue basis if Your Medicare Advantage plan was terminated.

Question:
1) Has Your Medicare Advantage plan been terminated?
Y or N
☐ ☐ **If YES, You may qualify for Open Enrollment. Skip to Section 8.**

GUARANTEED ISSUE
During Guaranteed Issue periods, we must sell You one of the required Medicare Supplement policies at the best price for Your age, without a waiting period or health screening.

Please answer all questions regarding Open Enrollment eligibility to the best of Your knowledge.

A. Reduction of Employer-Sponsored Retiree Benefits or Loss of Eligibility
You have the right to purchase certain Medicare Supplement plans if Your employer-sponsored retiree plan stops providing supplemental benefits to Medicare, You lose eligibility due to divorce or death of a spouse or family member, or Your retiree plan stops paying the Medicare Part B 20% co-insurance for services.

Questions:
1) Has Your employer-sponsored retiree plan stopped providing Medicare Supplement benefits or the Medicare Part B 20% co-insurance for services?
Y or N
☐ ☐ **If YES, You may qualify for Guaranteed Issue. Skip to Section 8.**
2) Have You lost eligibility for an employer-sponsored retiree plan due to divorce or death of a spouse or family member?
Y or N
☐ ☐ **If YES, You may qualify for Guaranteed Issue. Skip to Section 8.**
3) Has Your Medicare Advantage plan increased Your premium or co-payments by 15% or more, reduced Your benefits, or terminated its relationship with Your medical provider who was treating You?
Y or N
☐ ☐ **If YES, You may qualify for Guaranteed Issue. Skip to Section 8.**

B. Moving Out of Medicare Advantage (MA) Plan or PACE Organization Service Area
You have the right to purchase certain Medicare Supplement plans if You move out of the area of Your Medicare Advantage (MA) plan or Program for All-Inclusive Care for the Elderly (PACE) organization. You have the right to buy a Medicare Supplement policy even when MA plans and PACE organizations are available in Your new area.

Question:
1) Have You moved out of the area of Your Medicare Advantage (MA) plan or Program for All-Inclusive Care for the Elderly (PACE) organization?
Y or N
☐ ☐ **If YES, You may qualify for Guaranteed Issue. Skip to Section 8.**

C. Medicare Plan Fraud, Loss of Contract, Misrepresentation or Failure to Meet Contractual Obligations
You have the right to purchase certain Medicare Supplement plans if Your Medicare Advantage (MA) plan, Medicare SELECT Plan, PACE provider or any other health plan under contract with Medicare:
- commits fraud
- ends or loses its contract with Medicare
- misrepresents the plan You bought
- has failed to meet its contractual obligations to Medicare beneficiaries, as determined by the federal government

Question:
1) Has Your Medicare Advantage (MA) plan, Medicare SELECT plan, (PACE) provider or any other health plan under contract with Medicare: (a) committed fraud; (b) ended or lost its contract with Medicare; (c) misrepresented the plan You bought, or (d) failed to meet its contractual obligations to Medicare beneficiaries, as determined by the federal government?
Y or N
☐ ☐ **If YES, You may qualify for Guaranteed Issue. Skip to Section 8.**

D. Medicare Trial Period No. 1

You have the right to purchase certain Medicare Supplement plans during Medicare Trial Period No. 1: You joined a Medicare Advantage (MA) plan or Program for All-Inclusive Care for the Elderly (PACE) organization when You first became eligible for Medicare at age sixty-five (65), and You want to switch to a Medicare Supplement policy during Your first twelve (12) months in the MA plan or PACE organization.

If You were previously in an MA or PACE organization, You are not eligible for this guaranteed-issue right.

Questions:

1) Did You join a Medicare Advantage (MA) plan or Program for All-Inclusive Care for the Elderly (PACE) organization when You first became available for Medicare at age sixty-five (65)?

   Y or N
   ☐ ☐ **If YES, please answer question 2.**

2) Do You want to switch to a Medicare Supplement policy during Your first twelve (12) months in the MA or PACE organization?

   Y or N
   ☐ ☐ **If YES to both questions 1 and 2, You may qualify for Guaranteed Issue.** **Skip to Section 8.**

E. Medicare Trial Period No. 2

You have the right to purchase certain Medicare Supplement plans during Medicare Trial Period No. 2: You switch from a Medicare Supplement policy to a Medicare Advantage (MA) plan, Program for All-Inclusive Care for the Elderly (PACE) organization, Medicare SELECT plan, or any other health care organization contracting with Medicare, for the first time since becoming eligible for Medicare, and You disenroll from that plan within the first twelve (12) months. You have the option to return to Your previous Medicare Supplement policy if it is still available. If it is not available, You can choose plans A, B, C, F, K, L, M or N from any company.

Question:

1) Have You switched from a Medicare Supplement policy to a Medicare Advantage (MA) plan, Program for All-Inclusive Care for the Elderly (PACE) organization, Medicare SELECT plan, or any other health organization contracting with Medicare, for the first time since becoming eligible for Medicare within the past twelve (12) months?

   Y or N
   ☐ ☐ **If YES, You may qualify for Guaranteed Issue.** **Skip to Section 8.**

F. Medicare Advantage (MA) Plan Terminates Coverage in Your Area

You have the right to purchase certain Medicare Supplement plans if your Medicare Advantage (MA) plan leaves Your area. You can apply anytime after the MA plan notifies You, on a Guaranteed Issue basis, if You apply within 123 days of the end of Your MA plan benefits.

Questions:

1) Has Your Medicare Advantage (MA) plan left Your area?

   Y or N
   ☐ ☐ **If YES, answer next question 2.**

2) Did Your MA plan benefits end within the past 123 days?

   Y or N
   ☐ ☐ **If YES to both questions 1 and 2, You may qualify for Guaranteed Issue.** **Skip to Section 8.**

G. Medicare Supplement plan with Medicare Part D

You have the right to purchase a Medicare Supplement plan if You were enrolled in Medicare Part D during the initial enrollment period, and at the same time, was enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and You terminate enrollment in the Medicare Supplement policy.

Question:

1) Have You terminated Your Medicare Supplement policy and You are enrolled in Medicare Part D?

   Y or N
   ☐ ☐ **If YES, You may qualify for Guaranteed Issue.** **Skip to Section 8.**

If You answered YES to any of the questions in Section 6, Your acceptance may be guaranteed, and You are not required to answer any health questions. **Skip to Section 8.**

If You answered NO to all questions, go to the next section (Section 7).

SECTION 7: MEDICAL QUESTIONS

If You were instructed to skip to Section 8 or believe You are eligible for Open Enrollment or Guaranteed Issue, do not complete this section.

It is important that You provide truthful and accurate answers to the questions in this section as Your answers form the basis of our determination of Your eligibility for this coverage as well as underwriting requirements. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage. After two (2) years from the date of issuance of this policy, no misstatements, except fraudulent misstatements, made by the Applicant in the Application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the two (2) year period.

CALIFORNIA LAW PROHIBITS HIV TESTING FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

For all plans, answer questions 1-31.

PART A: MEDICAL QUESTIONS - Please answer all the questions to the best of Your knowledge.

	YES	NO	NOT SURE
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?	☐	☐	☐
2) Do You require or receive any assistance with bathing, transferring, toileting, eating, or dressing?	☐	☐	☐
3) Are You currently bedridden or do You use the assistance of a wheelchair, walker, or motorized mobility aid?	☐	☐	☐
4) Within the past two (2) years, have You:			
a) been diagnosed with a terminal illness or been hospitalized more than two (2) times, received home health care services more than three (3) times, or been confined to a nursing facility for more than thirty (30) days?	☐	☐	☐
b) been diagnosed with or treated (other than with maintenance medication) for angina, heart attack, atrial fibrillation, cardiomyopathy, congestive heart failure, cardiac or vascular angioplasty, stent placement, peripheral vascular disease, coronary bypass, carotid artery disease, coronary artery disease, or heart disease; had heart or heart valve surgery or required the implantation of cardiac pacemaker or defibrillator?	☐	☐	☐
c) had a stroke or Transient Ischemic Attack (TIA) (sometimes referred to as a "mini stroke")?	☐	☐	☐
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 hepatitis (other than hepatitis A), cirrhosis of the liver, or other liver disease?	☐	☐	☐
6) 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 major depression, bipolar disorder, schizophrenia, or a paranoid disorder?	☐	☐	☐
7) 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 diabetes with hypertension which requires more than two medications to control, diabetes requiring more than 50 units of insulin daily to control, or diabetes with any of the following: neuropathy, retinopathy, or vascular disease?	☐	☐	☐
8) 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 chronic kidney disease, Addison's Disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, or pancreatitis?	☐	☐	☐
9) 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 any condition requiring an organ transplant?	☐	☐	☐
10) 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 internal cancer, leukemia, malignant melanoma, Hodgkin's Disease, or lymphoma?	☐	☐	☐
11) 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 alcohol or drug abuse?	☐	☐	☐
12) 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 paralysis?	☐	☐	☐
13) 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 hemophilia?	☐	☐	☐
14) 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 osteoporosis with fractures?	☐	☐	☐

	YES	NO	NOT SURE
15) 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 an aneurysm that has not been surgically repaired? ...	☐	☐	☐
16) 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 Paget's Disease, rheumatoid or disabling arthritis, or systemic lupus? ...	☐	☐	☐
17) Do You have now or in the last five (5) years have You received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for Parkinson's Disease, myasthenia gravis, multiple or amyotrophic lateral sclerosis (Lou Gehrig's Disease)? ...	☐	☐	☐
18) Do You have now or in the last five (5) years have You received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for muscular dystrophy, cerebral palsy, dementia, senility, Alzheimer's Disease, or organic brain disorder? ...	☐	☐	☐
19) Do You have now or in the last five (5) years have You received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic Obstructive Lung Disease (COLD), or any chronic lung or respiratory disorder requiring the use of oxygen? ...	☐	☐	☐
20) Do You have now or in the last five (5) years have You received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for amputation caused by disease? ...	☐	☐	☐
21) Do You have now or in the last five (5) years have You received medical advice, treatment, or been advised to have an organ transplant, other than corneas? ...	☐	☐	☐
22) In the past five (5) years, have You been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS); or AIDS Related Complex (ARC)? ...	☐	☐	☐
23) 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 or any other blood disorder? ...	☐	☐	☐
24) In the past two (2) years, have You been advised by a medical professional to have surgery to correct any medical condition that has not been performed, or have You scheduled any surgery which has not been completed? ...	☐	☐	☐
25) Have medical tests (other than mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only), treatment, or therapy been advised but not performed? ...	☐	☐	☐

PART B: MEDICAL QUESTIONS - Please answer all the questions to the best of Your knowledge.
Please provide complete details as requested below.

	YES	NO	NOT SURE
26) Within the past two (2) years, have You been declined for Life, Health, or Supplemental Insurance? ...	☐	☐	☐

If YES, please provide details including the date of the declination, the type of coverage applied for, and the reason for the declination here ______________________________

____

27) Have You used tobacco within the last twelve (12) months*? ...	☐	☐	☐

*Answering this question is voluntary. Loyal American Life Insurance Company offers reduced rates for non-tobacco users. In order to take advantage of the reduced rates, You must answer this question.

28) Applicant's: Height (ft.-in.) _________ Weight (lbs.) _______

29) In the past two (2) years, have You had PSA levels greater than 6.0 or been diagnosed with dysplasia of the cervix classified as a level 3.0 or higher? ...	☐	☐	☐

If YES, please provide details in the table below.

Test	Results	Diagnosis

30) Within the past two (2) years, have You taken any medication for any heart or vascular disease other than hypertension? ...	☐	☐	☐

If YES or if You are taking any medications, give complete details in Part C Medications.

PART C: PRESCRIPTION MEDICATIONS

31) Please list any prescription medications taken or prescribed in the past two (2) years.
If You are not taking any prescription medications, please check here: ☐ I am not taking any prescription medications.

Prescription Medication	Dates Taken	Condition Taken for

SECTION 8: IMPORTANT STATEMENTS FOR APPLICANT TO READ

- You do not need more than one (1) 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 Medi-Cal and may not need a Medicare Supplement policy.
- If, after purchasing this policy, You become eligible for Medi-Cal, the benefits and premiums under Your Medicare Supplement policy can be suspended, if requested, during Your entitlement to benefits under Medi-Cal for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medi-Cal. If You are no longer entitled to Medi-Cal, Your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing Medi-Cal eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and You enrolled in Medicare Part D while Your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to Your coverage before the date of 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 reinstituted if requested within ninety (90) days of losing Your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and You enrolled in Medicare Part D while Your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to Your coverage before the date of the suspension.
- Counseling services may be available in Your state to provide advice concerning Your purchase of Medicare Supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB). If You want to discuss buying Medicare Supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP (4357), and ask how to contact Your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.
- A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP (4357)), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet Web site (www.insurance.ca.gov).

I hereby apply to Loyal American Life Insurance 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) a policy has been issued by the Company and (b) the initial premium has been paid; and (3) I have received the Outline of Medicare Supplement Coverage for the policy applied for, the required "Guide to Health Insurance for People with Medicare," and the MIB Notice.

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.

I ☐ ***grant*** ☐ ***do not grant*** my authorization to receive information or presentation of materials describing other insurance products.

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 fines and confinement in prison.

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 ____________________

SECTION 9: AGENT(S) CERTIFICATION

Agents have the duty to assist the Applicant in providing answers to health questions accurately and completely. Agents shall list any health insurance policies they have sold to the Applicant.

1) List policies sold which are still in force (if this does not apply, state "NONE"): ______________________

____

____

2) List policies sold in the past five (5) years which are no longer in force (if this does not apply, state "NONE"):

____

____

____

	YES	NO
3) Have You submitted any applications or have knowledge of any applications submitted for this Applicant that have been declined? ...... If YES, provide details below.	☐	☐

____

____

4) Have You reviewed the Application for correctness and omissions?	☐	☐

5) I certify that I have provided the Applicant with the following documents:

a) Application Packet (Phone Sales only)
b) *A Guide to Health Insurance for People with Medicare*
c) Outline of Medicare Supplement Coverage
d) MIB Notice
e) Other ______________________________

I further certify that I have delivered the documents to the Applicant (check all that apply; must select at least one):

☐ In person ______________ date
☐ Mail ______________ date
☐ Email ______________ date
☐ Fax ______________ date
☐ Other (explain) ______________ ______________ date

	YES	NO
6) Was the Application completed by You in the Applicant's physical presence?	☐	☐
7) Was the Application completed by You over the phone?	☐	☐
8) Do You have knowledge or reason to believe the replacement of existing insurance may be involved?	☐	☐

If YES, give name of Company, reason, and termination date ______________________

____

____

____

I attest that I have interviewed the Applicant, asked all of the questions as written on the Application, and I have truly and accurately recorded on the Application the information supplied to me by the Applicant.

I further attest that to the best of my knowledge, the information on the Application is complete and accurate. I have explained to the Applicant, in easy-to-understand language, the risk to the Applicant of providing inaccurate information and that the Applicant understood the explanation. If, in this required attestation, a declarant willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies available under the current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring civil action to impose that civil penalty. The penalties shall be paid to the Insurance Fund.

Printed Name of 1st Licensed Agent	Signature of 1st Licensed Agent	Writing Number	Percentage
Printed Name of 2nd Licensed Agent	Signature of 2nd Licensed Agent	Writing Number	Percentage

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

LOYAL AMERICAN LIFE INSURANCE COMPANY® • PO 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 - 28th)

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group ____________________

Purpose for submitting this Authorization (check appropriate box(es)):

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

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

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

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 Loyal American Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Loyal American Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Loyal American Life Insurance Company mistakenly deposits funds into my account, I authorize Loyal American Life Insurance to debit my account for an amount not to exceed the original amount of credit. 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 LOYAL AMERICAN LIFE INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent 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 association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Loyal American Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Loyal American Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Loyal American Life Insurance Company 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**

MIB, Inc., Pre-Notice

LOYAL AMERICAN LIFE INSURANCE COMPANY®

PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

Information regarding your insurability will be treated as confidential. Loyal American Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Loyal American Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

AUTHORIZATION FORM FOR DISCLOSURE 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 Loyal American Life Insurance Company®.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., 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. However, MIB, Inc., information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB, Inc.
4. 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.
5. 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 Office at PO Box 26580, Austin, Texas 78755-0580.
6. 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.
7. 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 re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
8. 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.
9. 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.

AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER'S PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES ("Authorization")

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization 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 Steward at PO Box 26580, Austin, Texas 78755-0580.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing 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 is 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. This Authorization will expire twenty-four (24) months from the date it is signed.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer's behalf:

____

Consumer's Name	**Name of Consumer's Personal Representative, if applicable**
Signature of Consumer **Date**	**Relationship of Personal Representative to the Consumer**
Signature of Company's Agent **Date**	**Signature of Personal Representative** **Date**

A signed copy of this form will be provided to you.

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 Loyal American Life Insurance Company (LALIC) 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

LOYAL AMERICAN LIFE INSURANCE COMPANY®

PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

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 LALIC. 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) ________________________________

NOTE:

1. 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 note 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the Application concerning your medical and health history. Failure to include all material medical information on an Application may provide a basis for the company to deny any future claims and to refund your premiums as though your policy had never been in force. After the Application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

______________________________ **Agent's Signature**

______________________________ **Applicant's Signature**

______________________________ **Type or Print Name and Address of Agent/Broker**

______________________________ **Date**

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☐ no change in benefits, but lower premiums

☐ fewer benefits and lower premiums

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☐ disenrollment from a Medicare Advantage Plan – please explain reason for disenrollment ________________________

☐ other (please specify) ________________________

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________________________ ________________________

Agent's Signature **Applicant's Signature**

________________________ ________________________

Type or Print Name and Address of Agent/Broker **Date**