

SECTION 1 Applicant Information

First Name	Middle Initial	Last Name	Social Security Number - -	
Primary Street Address (No P.O. Box)		City	State	ZIP Code
Mailing Street Address (if different from above)		City	State	ZIP Code
Phone number that we may use to contact you ()		Alternative phone number that we may use to contact you (optional) ()		
E-mail address		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date / /	

Secondary Addressee (for purpose of notification of a past due premium payment and possible lapse in coverage)

First Name	Middle Initial	Last Name		
Address		City	State	ZIP Code

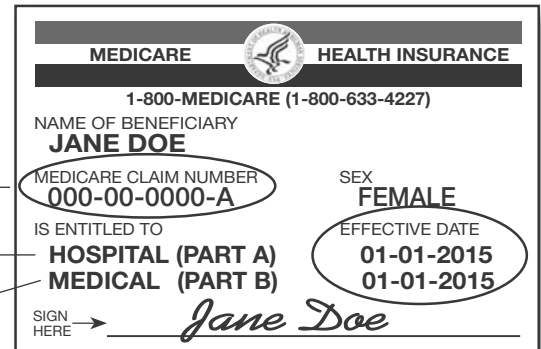
Medicare Claim Number & Effective Date

Please reference your Medicare card to complete this Section. This information must be provided for us to complete your application process. To be considered for coverage, you must have Medicare Parts A and B.

Medicare Claim Number - -

Part A Effective Date

Part B Effective Date



MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
NAME OF BENEFICIARY
JANE DOE
MEDICARE CLAIM NUMBER
000-00-0000-A
SEX
FEMALE
IS ENTITLED TO
HOSPITAL (PART A)
MEDICAL (PART B)
EFFECTIVE DATE
01-01-2015
01-01-2015
SIGN HERE *Jane Doe*

SECTION 2 Plan Selection & Payment Options

You must be enrolled in Medicare Part A and B, you cannot have more than one Medicare Supplement Plan and cannot be enrolled in a Medicare Supplement and Medicare Advantage plan at the same time.

I would like to apply for the following Medicare Supplement insurance plan: **(check only one box)**

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan F ☐ Plan G ☐ Plan N Not all plans are available in all states.

Payment Amount

Initial Premium: \$ plus a one-time application fee of \$15 = \$

Make Policy Effective: The policy **cannot** be effective prior to the application date or on the 29th, 30th, or 31st of the month

PAYMENT OPTIONS (Check only one box)

ELECTRONIC FUNDS TRANSFER

(Complete the Electronic Funds Transfer Authorization form)

☐ Monthly ☐ Every Six Months
☐ Every Three Months ☐ Every Twelve Months

— OR —

DIRECT BILL

☐ Every Three Months
☐ Every Six Months ☐ Every Twelve Months

SECTION 3 Open Enrollment Period

1. Did you turn 65 within the last 6 months, or will you be at least 65 years of age during the month of your selected effective date?
☐ Yes ☐ No
2. Did you enroll in Medicare Part B within the last 6 months?
☐ Yes ☐ No

NOTE: If you answer "yes" to all questions in Section 3, you are eligible for Open Enrollment. You may skip SECTION 4 and the Health Questions in Section 6.

SECTION 4 Guaranteed Issue Period

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for Guaranteed Issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans.

Please include a copy of the notice from your prior insurer with your application.

Please answer all questions below to the best of your knowledge. Select "Yes" or "No" by placing an "X" in the corresponding box.

1. Do you have another Medicare supplement policy in force? ☐ Yes ☐ No
If Yes, answer the following questions.

a. With what company, and what plan do you have? _____

- b. Do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No
If Yes, you must complete Oxford Life replacement form.

2. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ☐ Yes ☐ No
If Yes, answer the following questions.

a. With what company, _____ and what kind of policy? _____

b. What are the dates of coverage under the other health insurance policy?

If you are still covered under this plan, place an "X" here ☐ and leave "END" blank.

START END
 MONTH DAY YEAR MONTH DAY YEAR

3. Have you had coverage from any Medicare plan other than the original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) ☐ Yes ☐ No
Fill in your start and end dates below (If you are still covered under this plan, leave "END" blank.)

START END
 MONTH DAY YEAR MONTH DAY YEAR

- a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ Yes ☐ No
- b. Was this your first time enrolled in that type of Medicare plan? ☐ Yes ☐ No
- c. Did you drop a Medicare supplement policy to enroll in that Medicare plan? ☐ Yes ☐ No

SECTION 4

— continued

4. Guaranteed Issue Eligibility

a. Have any of the following events listed below occurred? Please place an "X" in the appropriate box.

You were enrolled in employer/retiree group health coverage (including COBRA coverage) and canceled because you could no longer be covered under the terms of the plan, voluntarily left the plan, the company is canceling the plan in its entirety, or your COBRA coverage ended ☐ Yes ☐ No

You were enrolled in a Medicare Advantage (including Medicare HMO or PPO) plan, a Medicare Select plan or a PACE program when you were age 65 or older and you were disenrolled because (1) you moved out of the service area, (2) your plan withdrew from your service area, (3) the certificate of the organization or plan has been terminated, (4) the organization violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Sub chapter XVIII, Part D in relation to you, including failure to provide you on a timely basis medically necessary care for which benefits are available under the plan or to provide such covered care in accordance with applicable quality standards, (5) the organization, producer, or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in the marketing plan or (6) you enrolled for the first time since you became Medicare Eligible at age 65 or older and decided to disenroll within one year of initial enrollment ☐ Yes ☐ No

You had an Oxford Life Medicare supplement plan and then canceled it to enroll, for the first time, in a Medicare Advantage (including Medicare HMO or PPO) plan, a Medicare Select plan or a PACE program within the last 12 months, and then you disenrolled from your new plan within one year of initial enrollment. Please note: If you were involuntarily terminated within the first 12-month period and, without intervening enrollment, enrolled with another such organization, the subsequent enrollment shall be deemed to be the initial enrollment ☐ Yes ☐ No

You were enrolled in a Medicare supplement plan and your previous carrier ended your coverage through no fault of your own, including the carrier violating a material provision of the policy, or the carrier, producer or other entity acting on the carrier's behalf materially misrepresented the policy's provisions in marketing the policy. ☐ Yes ☐ No

You were enrolled in a Medicare Part D plan during the initial enrollment period, had an Oxford Life Medicare supplement policy with outpatient prescription drug coverage during such period, but terminated the Oxford Life Medicare supplement policy because of the Part D plan prior to 63 days after the effective date of your coverage under Medicare Part D. ☐ Yes ☐ No

You are age 65 or older, covered under Medi-Cal but have lost Medi-Cal entitlement, and are enrolled in Medicare Parts A and B. ☐ Yes ☐ No

You are under age 65, covered under Medi-Cal but have lost Medi-Cal entitlement, and are enrolled in Medicare Parts A and B. (You are eligible for Plan A only, except in Missouri, in which case you are eligible for Plan A or F.) ☐ Yes ☐ No

b. Are you applying before the 63rd day after your coverage terminated? ☐ Yes ☐ No

If you answered yes to 4(a) and 4(b) you are eligible for guarantee issue and you are not required to answer the health questions in SECTION 6.

SECTION 5

Benefits under Medi-Cal

1. Are you covered for medical assistance through the state Medi-Cal program? (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) ☐ Yes ☐ No

If Yes, answer the following questions.

a. Will Medi-Cal pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No

b. Do you receive any benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No

SECTION 6 Health History/ Medical Questions

A. IF YOU ARE 64 YEARS OF AGE OR YOUNGER, PLEASE ANSWER THE FOLLOWING HEALTH HISTORY QUESTION:

Have you ever been medically diagnosed, treated, or taken medication for end-stage kidney (renal) failure?

☐ Yes ☐ No ☐ Not Sure

Please answer the following questions only if you are eligible for Guaranteed Issue.

Note: If you are in Open Enrollment or if you have determined that you are eligible for Guaranteed Issue, you are not required to answer the following health questions.

1. What is your height _____ ft. _____ in. and weight _____ in lbs?

a. Within the past 12 months, have you used any nicotine based products, any form of electronic cigarette (including nicotine-free electronic cigarettes) or marijuana? ☐ Yes ☐ No

Section A

If you answer "Yes" to any of the questions in this section, no coverage will be issued.

2. Are you currently hospitalized, confined to a bed, nursing or hospice facility, unable to perform daily activities without assistance or do you have, or been advised by a medical professional that you have, any disease, injury or impairment that will require hospitalization, surgery, or treatment for which you have not sought medical attention?

☐ Yes ☐ No ☐ Not Sure

3. Have you had, or been medically advised to have, an organ transplant?

☐ Yes ☐ No ☐ Not Sure

4. a. Have you ever been medically diagnosed, treated, or taken medication for congestive heart failure, cardiomyopathy or Alzheimer's disease, dementia or cirrhosis, liver failure, chronic hepatitis, or chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, end-stage kidney (renal) failure, kidney dialysis, glomerulonephritis, nephropathy, interstitial nephritis or amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), Hodgkin's disease, Parkinson's disease, or lymphoma?

☐ Yes ☐ No ☐ Not Sure

b. Have you in the last 5 years been medically diagnosed, treated, or taken medication for ataxia, cystic fibrosis, multiple sclerosis, myasthenia gravis, organic brain syndrome, peripheral neuropathy, or Huntington's chorea, or any lung disease or kidney disease not already listed in Question 4a above?

☐ Yes ☐ No ☐ Not Sure

5. Have you ever been diagnosed as having, or told by a medical doctor that you have acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?

NOTE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance

☐ Yes ☐ No ☐ Not Sure

6. Within the past 2 years, have you been confined in a hospital, convalescent facility, nursing home or custodial care facility two or more times?

☐ Yes ☐ No ☐ Not Sure

7. Within the past 3 years, have you been diagnosed with internal cancer or melanoma, or had more than one occurrence of cancer or any metastasis (excluding surgically removed basal or squamous cell skin cancer), or are you currently being treated for cancer or reoccurrence of cancer?

☐ Yes ☐ No ☐ Not Sure

Section B

If you answer "Yes" to any of the questions in this section, additional information may be requested during the telephone interview, and may result in no coverage being issued.

8. Have you been medically diagnosed as having or currently taking medications for diabetes, Crohn's disease or ulcerative colitis?

☐ Yes ☐ No ☐ Not Sure

9. Within the past 2 years, have you been medically diagnosed, treated or hospitalized for angina, heart attack, heart disease, coronary artery disease, heart or circulatory/vascular surgery (including pacemaker, by-pass, heart valve replacement, angioplasty, heart or other stent placement)?

☐ Yes ☐ No ☐ Not Sure

10. Within the past 3 years, have you been diagnosed, treated for, or been advised to have treatment for alcohol or drug abuse or been diagnosed as having a stroke or transient ischemic attack (TIA)?

☐ Yes ☐ No ☐ Not Sure

11. Are you taking medication for any impairment or condition not indicated in Section 6?

☐ Yes ☐ No ☐ Not Sure

SECTION 7

Important Authorization and Verification Information

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, the MIB, (formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its members) pharmacy, pharmacy benefit manager, laboratory, my employer or consumer reporting agency, to give the Company or its reinsurers any information they have about my health, including sexually transmitted diseases. I authorize Oxford Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. **An applicant who qualifies for open enrollment or guaranteed issue is not subject to disclosure of information from MIB or other consumer reporting agencies as a condition of obtaining coverage.** This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for use in underwriting risk selection purposes only and is valid for 24 months from the date below. A copy of this authorization is as valid as the original. This protected health information is to be disclosed under the authorization at my request, as permitted by § 164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule").

I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company addressed, Attention: Policyholder Service Department, 2721 North Central Avenue, Phoenix, AZ 85004. I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my providers to release and disclose the entire medical record without restriction.

I understand that my providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, the Company may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

I understand and agree that the information on this application will be relied on to determine insurability and that incorrect information may result in coverage being voided.

SIGNATURE

Applicant's Signature: _____

Applicant's Name: _____

Date Signed: _____

SECTION 8

PROPOSED INSURED'S STATEMENT

1. I read or had read to me the completed application and agree that I understood it.
2. I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief.
3. I am over 18, I am not taking or under the influence of any alcohol, medications or drugs that affect my ability to fully understand and accurately complete this application and I am otherwise not impaired.
4. I understand that the producer has not authority to approve the application, change the policy, or waive any policy provisions.
5. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met.
6. I acknowledge receipt of A Guide to Health Insurance for People with Medicare and an Outline of Coverage. (Not applicable for Direct-to-Consumer business)
7. I am applying for Medicare Supplement coverage. I certify that I am enrolled in Both Part A and Part B Medicare.
8. I assign Oxford Life my entire right of recovery of the cost of hospital and medical services paid for by Oxford Life against any person or organization as a result of accident or disease, including injuries or disease claimed under workers' compensation laws or acts whether by redemption award, voluntary payment or otherwise.
9. I understand the information will be used in reviewing my application and administering coverage and my failure to provide complete and accurate answers or my submission of false or misleading information may result in denial of claims, cancellation or rescission of the policy.
10. I certify that I am not eligible for group health insurance as an active employee or dependent through my or my spouse's employer or former employer.
11. I understand that if my answers on this application are incorrect or untrue, Oxford Life Insurance Company may deny benefits, cancel and/or void the policy for which I applied.
12. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Oxford Life Insurance Company.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.

I acknowledge that I have read and understand the statements above and have received disclosures concerning the Fair Credit Report Act, MIB Notifications and information regarding Medicare Supplement coverage.

SIGNATURE

Applicant's Signature: _____

Applicant's Name: _____

Date Signed: _____

SECTION 9 To be Completed by Producer

List any other health insurance policies or coverages sold to the applicant, which are still in force.

List any other health insurance policies or coverages sold to the applicant within the last 5 years which are no longer in force.

I understand that I represent the interest of the applicant for insurance, and have advised the applicant not to terminate any existing coverage until receiving notice that the coverage being applied for by this application is approved. I understand that I have no right to bind this coverage, to alter terms of the insurance contract or application in any manner, or to adjust any claim for the benefits under the entire contract. I have not backdated this application.

I certify that to the best of my knowledge, the information on the application is complete and accurate. I further certify that I 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 you state as a producer any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars (\$10,000).

Producer's Signature: _____ Producer # _____

Producer Name: _____

Date Signed: _____

Producer Split /	Producer #	<input type="text"/>	Split %	<input type="text"/>	Producer #	<input type="text"/>	Split %	<input type="text"/>
	Producer #	<input type="text"/>	Split %	<input type="text"/>	Producer #	<input type="text"/>	Split %	<input type="text"/>

Deliver Policy To: ☐ Producer ☐ Applicant

DISCLOSURE

Leave this page with the Applicant for their records.

FAIR CREDIT REPORTING ACT NOTICE

With regard to Your application, We may request a consumer report or an investigative consumer report. These reports contain information about Your character, general reputation, mode of living and health. No adverse underwriting decision will be made based on Your sexual orientation. The information may have been obtained through interviews with You, Your neighbors, friends and others who know You. Upon request, We will give You the name and address of the consumer reporting agency so that You may request a copy of the report.

NOTIFICATION REGARDING MIB, INC.

Information regarding Your insurability will be treated as confidential. Oxford Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to MIB, Inc. ("MIB"), formerly known as the 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 company, the MIB, upon request, will supply such company with the information about You 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, Massachusetts 02184-8734. Oxford Life Insurance Company, or its reinsurers, may also release information from its file to MIB and to other life or health 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.

You authorize Oxford Life Insurance Company, and its reinsurers, to make a brief report of Your personal health information to MIB, Inc.

IMPORTANT INFORMATION REGARDING MEDICARE SUPPLEMENT COVERAGE

You do not need more than one Medicare supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits. 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 24 months. You must request this suspension within 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 reinstated if requested within 90 days of losing Medi-Cal eligibility.* If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan.*

*If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and/or concerning medical assistance through Medi-Cal, including benefits as a Qualified Medicare Beneficiary(QMB) and a Specified Low-Income Medicare Beneficiary(SLMB). For questions on Medicare supplement insurance, call 1-800-MEDICARE (1-800-633-4227). I have read and understand this information.

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, and ask how to contact your local Health Insurance Counseling Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

**AUTHORIZATION FOR COLLECTION,
USE AND DISCLOSURE OF PERSONAL INFORMATION**

Name(s) of Primary Proposed Insured/Patient

Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, consumer reporting agency, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB, Inc. ("MIB") or any of its members or affiliates), government agency, or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf (collectively, "My Providers") to release and disclose any information they have about my health, including my entire medical record, to the company referenced on this authorization ("the Company"), their affiliates and reinsurers, and all other persons authorized to represent the Company. This includes information on the diagnosis and treatment of communicable or infectious diseases, such as Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I understand that my personal health information will be used for the purposes of underwriting risk selection, and for determining the insured's eligibility for benefits and the contestability of the insurance policy. I further expressly authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

This authorization shall remain in force for 24 months (or such longer period as may be permitted by law) following the date of my signature below, regardless of my condition and whether living or deceased. I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization. I agree that a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company addressed, [**Attention: Policyholder Services Department, 2721 North Central Avenue, Phoenix, AZ 85004.**] I understand that my revocation will not affect the rights of any person who has acted in reliance on the authorization prior to receiving notice of my revocation, or to the extent that the Company has a legal right to contest a claim under the insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and that the information may no longer be protected by federal regulations governing privacy and confidentiality.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application, make a determination as to whether coverage will be offered, or if coverage has been issued, determine whether benefits are payable. I understand that I, or any person that is authorized to act on my behalf, is entitled to receive a copy of this authorization. I understand that I will receive a copy of this authorization.

I confirm and agree that my act of typing my name below or clicking "I Agree" constitutes my electronic signature on this HIPAA authorization, which I understand and agree is fully in enforceable under state and federal law without any further act by me or any third party.

Signature of Insured

Date

If signed by an individual's Personal Representative, describe authority to sign on behalf of the individual:

† Power of Attorney (Please attach) † Other (please describe): _____

Proposed Insured Policy or contract number (If known): _____

PREMIUM RECEIPT FOR MEDICARE SUPPLEMENT POLICY

NOTE: MAKE ALL CHECKS PAYABLE TO: OXFORD LIFE INSURANCE COMPANY

— *To be completed only when a check is received by the agent* —

No insurance shall become effective based on this receipt unless the proposed insured is insurable on the basis stated below.

Received from _____ the sum of \$ _____

and an application for Medicare supplement insurance with the Company bearing the same date as this receipt. If, in accordance with the Company's underwriting rules, the applicant is rejected by the Company, the Company will refund the full amount paid in exchange for this receipt. This receipt shall be void if it is given for a check which is not honored upon presentation to the bank.

Producer Name _____ Date _____


IF YOU DO NOT HEAR FROM THE COMPANY WITHIN 30 DAYS OF THIS RECEIPT PLEASE NOTIFY:

ATTN: POLICYHOLDER SERVICES DEPARTMENT

/ 4 / . K l a p @ b k o i s b k r b M l b k f u W 5 2 - - 1

866-641-9999 www.oxfordlife.com

POLICY NUMBER:		BANK ACCOUNT TYPE: CHECKING SAVINGS	
BANK ACCOUNT OWNER NAME SAME AS INSURED or PRINT NAME:			
BANK ACCOUNT OWNER ADDRESS		RELATIONSHIP TO INSURED	
BANK NAME	ROUTING NUMBER	BANK ACCOUNT NUMBER	
<p>Use this section if you would like to request that we draft premium payments from your bank account on a specific date. If blank, the draft date will be the premium due date.</p> <p>Draft date request (between the st and th):</p>			



our Name	
our Address	
Routing Number	Account Number

I authorize Oxford Life Insurance Company to electronically debit all premiums (at the then-current rate for the payment frequency selected), including any past due premiums, from the bank account identified above. If the premium differs from the premium quoted on an application submitted with this form, I authorize Oxford Life to debit the actual premium amount due from my bank account. This authorization may be terminated by me or by Oxford Life. I may revoke this authorization by written notice to Oxford Life or by calling () - . If this authorization is revoked, Oxford Life will initiate quarterly paper billings. Oxford Life will NOT consider my premium paid if my bank does not honor an EFT request. If a bank return is received due to insufficient funds, Oxford Life will attempt a second draft from your bank account immediately upon notice of the first return. Any bank fees incurred due to bank returns will not be reimbursed by Oxford Life.

£

£

£

Signature – Insured Date Signature – Bank Account Owner Date

North Central Avenue, Phoenix, AZ	Phone	- -	Phone	- -	Phone	- -	
	Fax	- -	Fax	- -	Fax	- -	
	E-Mail	marketing oxfordlife.com	E-Mail	fastapps oxfordlife.com	E-Mail	oxfordphs oxfordlife.com	



**Oxford Life
Insurance Company**

PO Box 46518 Madison, WI 53744-6518
(877) 469-3073 www.oxfordlife.com

**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 coverage and replace it with a policy to be issued by Oxford 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. 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. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY ISSUER (OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health 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 reasons:

- ☐ Additional benefits.
- ☐ Same benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D, Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
- ☐ Other (specify) _____

I call to your attention the following items for your consideration:

If you are applying outside of an open enrollment or guarantee issue period:

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 issuer to deny any future claims and to refund your premium as though the policy had never been in force. After the application has been completed and before you sign it, read and review it carefully to be certain that all information has been properly recorded.

For all cases:

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Name and address of issuer or producer:

Producer Signature

Applicant Signature

Date