Florida

Producer Information – Please Complete

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

Preferred Method of Communication (Select one)

☐ Phone ☐ Fax ☐ Email Contact info: _____

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

Application Submission Checklist – Gerber Medicare Supplement/Select Coverage

- ☐ **Provide Applicant with the Guide to Health Insurance for People with Medicare**
- ☐ **Provide Applicant with the Outline of Coverage**
  - Calculate the premium based on age at application date
- ☐ **Complete the Calculate Your Premium form (T03_626) to determine rate**
- ☐ **Application (complete in full)**

Sections A & B: Plan and Applicant Information

- Select plan
- Enter Requested Effective Date
- Indicate where the policy is to be mailed

Section C: Medicare Information

- Include applicant's Medicare claim number on the application. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate "eligibility" and "enrollment" dates.

Section D: Previous or Existing Coverage Information

- Please complete ALL questions in full

For Sections E and F – Refer to the Open Enrollment/Guaranteed Issue worksheet (T03_633) to help identify eligibility.

Section E: Please answer all of the following questions

- If either Applicant A or B answered "YES" to question 5 OR BOTH questions 6 and 7 in Section E, they can skip to Section H

Sections F & G: Health/Medication Information

- Do NOT answer if applicant is in an open enrollment or guaranteed issue period

Section H: Agreement and Authorization

- Make sure applicant(s) sign and date the application

Section J: To be Completed by Producer

- Make sure producer(s) sign and date the application

- ☐ **Complete the Method of Payment form (T03_635) and return with the completed application**
  - Use premium determined by the **Calculate Your Premium form (T03_626)**
  - The full modal premium is collected at the time of application
- ☐ **Complete Replacement Notice (T03_202_FL) and leave a copy with the applicant (if applicable)**
- ☐ **Complete the Florida Certification Form (T03_215_FL) and leave a copy with the applicant**
- ☐ **Complete the Medicare Select Policy Disclosure Agreement (T03_203_FL) (if applicable)**
- ☐ **Provide Applicant with Premium Receipt signed by agent (if applicable), and provide Applicant with Notice of Information Practices (T03_364)**

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

T03_230_FL_0611

Open Enrollment and Guaranteed Issue Worksheet

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

ELIGIBILITY FOR OPEN ENROLLMENT

Applicant is:

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

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

ELIGIBILITY FOR GUARANTEED ISSUE

Evidence of eligibility is required for the following situations.

Applicant:

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

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

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

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

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

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

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

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

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

Acceptable Evidence of Eligibility:

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

T03_633

Gerber Life
Insurance Company

Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan

Applicant A _____

Applicant B _____

Before you begin: *Please go to the Height and Weight Chart on the next page to determine your eligibility for coverage, unless you are in an open enrollment or guaranteed issue period.*

	Steps	Example Rate displayed is used for calculation purposes only.	Applicant A	Applicant B
#1	**Age** Write in your age at the time of signing the application. **ZIP Code** Indicate your ZIP Code used to determine your rate.	65 51502		
#2	**Premium** Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.	$128.52		
#3	**Payment Options** To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	$128.52 monthly payment $385.56 quarterly payment $771.12 semiannual payment $1,542.24 annual payment		
#4	**Enrollment/Policy Fee** There is a one-time application fee of $25.00. **This will be collected with your initial payment and will NOT affect your renewal premiums amount.**	$128.52 + $25.00 = $153.52 Example shows initial payment (monthly schedule).		

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Height and Weight Chart

Eligibility

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

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

Medicare supplement insurance is underwritten by
Gerber Life Insurance Company
Administrative Office
P.O. Box 2271
Omaha, Nebraska 68103-2271

T03_626

Agent Writing # _____ FAV Key _____

Gerber Life Insurance Company

Application for Medicare Supplement Coverage

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

A. Plan Information (to be completed by Producer)

	Applicant A	Applicant B
Plan (select one)	☐ Plan A ☐ Plan F ☐ Plan G ☐ Select Plan F ☐ Select Plan G	☐ Plan A ☐ Plan F ☐ Plan G ☐ Select Plan F ☐ Select Plan G
Requested Effective Date	___ / ___ / ____	___ / ___ / ____
Deliver Policy to	Applicant A ☐ Producer ☐	Applicant B ☐ Producer ☐

B. Applicant Information

	Applicant A	Applicant B
Name (First/Middle/Last)		
Residence Address		
City		
State / ZIP		
Mailing Address (if different from residence address)		
City		
State / ZIP	ZIP _____	ZIP _____
Home Phone (area code)	___ – ___ – ____	___ – ___ – ____
E-mail Address		
Current Age / Date of Birth (mo / day / yr)	Current Age _____ Date of Birth ___ / ___ / ____	Current Age _____ Date of Birth ___ / ___ / ____
☐ Male ☐ Female		
Social Security #	___ – ___ – ____	___ – ___ – ____

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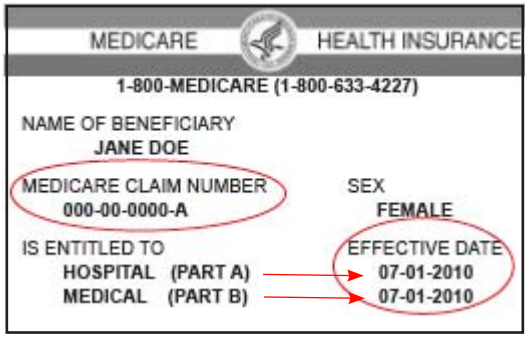
B. Applicant Information (continued)

Applicant A	Applicant B
Have you used tobacco in any form in the past 12 months? ☐ Y ☐ N	Have you used tobacco in any form in the past 12 months? ☐ Y ☐ N
If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease? ☐ Y ☐ N	If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease? ☐ Y ☐ N

C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A	Applicant B
Medicare Claim Number	Medicare Claim Number
Medicare Part A Effective Date __/__/____ If you are not covered under Medicare Part A, what is your eligibility date __/__/____	Medicare Part A Effective Date __/__/____ If you are not covered under Medicare Part A, what is your eligibility date __/__/____
Medicare Part B Effective Date __/__/____ If you are not covered under Medicare Part B, indicate the date you plan to enroll __/__/____	Medicare Part B Effective Date __/__/____ If you are not covered under Medicare Part B, indicate the date you plan to enroll __/__/____

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D. Previous or Existing Coverage Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. **Please include a copy of the notice from your prior insurer with your application.** PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

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

Please answer questions regarding another Medicare supplement or Select plan:

2. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....	☐ Y ☐ N	☐ Y ☐ N

(b) Indicate planned termination or disenrollment date..... Applicant A ☐☐/☐☐/☐☐☐☐

Applicant B ☐☐/☐☐/☐☐☐☐

(c) With what company, and what plan do you have?

Applicant A	**Applicant B**
Name of Company	Name of Company
Plan	Plan

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

	Applicant A	**Applicant B**
3. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO).....	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this previous or existing coverage:		

(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank..... Applicant A START ☐☐/☐☐/☐☐☐☐

END ☐☐/☐☐/☐☐☐☐

Applicant B START ☐☐/☐☐/☐☐☐☐

END ☐☐/☐☐/☐☐☐☐

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....	☐ Y ☐ N	☐ Y ☐ N

(c) Planned date of termination/disenrollment?..... Applicant A ☐☐/☐☐/☐☐☐☐

Applicant B ☐☐/☐☐/☐☐☐☐

(d) Was this your first time in this type of Medicare plan?.....	☐ Y ☐ N	☐ Y ☐ N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....	☐ Y ☐ N	☐ Y ☐ N
(f) Did you drop a union group or employer health plan to enroll in this Medicare plan?..	☐ Y ☐ N	☐ Y ☐ N

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(g) Please indicate reason for termination/disenrollment:	Check box(s) below if applicable Applicant A	Applicant B
■ Your Medicare Advantage plan is leaving the Medicare program.....	☐	☐
■ Your Medicare Advantage organization stopped offering Medicare Advantage plans.....	☐	☐
■ Your Medicare Advantage organization stopped offering coverage in the area in which you live.....	☐	☐
■ You moved out of the geographic service area of your Medicare Advantage plan.....	☐	☐
■ You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan.....	☐	☐

■ Other: _____
Applicant A

_____
Applicant B

Please answer questions regarding other health insurance:

	Applicant A	Applicant B
4. Have you had coverage under any other health insurance within the past 63 days?..... (For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)	☐ Y ☐ N	☐ Y ☐ N

If "YES," answer the following about this previous or existing coverage:

(a) What are your dates of coverage under the other policy/certificate?
If you are still covered under this plan, leave "END" blank..... Applicant A START ___/___/_____

END ___/___/_____

Applicant B START ___/___/_____

END ___/___/_____

(b) Planned date of termination/disenrollment?..... Applicant A ___/___/_____

Applicant B ___/___/_____

(c) With what company and what kind of policy/certificate? (List below.)

Applicant A	Applicant B
Name of Company	Name of Company
Policy/Certificate type	Policy/Certificate type

E. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
5. Are you applying during a guaranteed issue period?..... (NOTE: Refer to the guaranteed issue worksheet to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)	☐ Y ☐ N	☐ Y ☐ N
6. Did you turn age 65 in the last six months?.....	☐ Y ☐ N	☐ Y ☐ N
7. Did you enroll in Medicare Part B in the last six months?.....	☐ Y ☐ N	☐ Y ☐ N

If "YES," indicate your effective date..... Applicant A ___/___/_____

Applicant B ___/___/_____

STOP

IF EITHER YOU OR APPLICANT B ANSWERED "YES" TO QUESTION 5 OR BOTH QUESTIONS 6 AND 7 IN SECTION E, SKIP SECTIONS F & G AND GO TO SECTION H.

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

F. Health Information

For all plans, answer questions 8-18. The health questions below refer to condition, treatment or diagnosis that are provided by a physician.

(If "YES" is answered to any of the following questions 8-17, that person is not eligible for coverage.)

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

18. Applicant A (Height) Ft ☐☐ In ☐☐ (Weight) Lbs ☐☐☐

Applicant B (Height) Ft ☐☐ In ☐☐ (Weight) Lbs ☐☐☐

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G. Medication Information

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

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

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H. Agreement and Authorization

IMPORTANT STATEMENTS

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the 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 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 state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO GERBER LIFE INSURANCE COMPANY

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Gerber Life Insurance Company and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Gerber Life Insurance Company. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, Gerber Life Insurance Company, P.O. Box 2271, Omaha, NE 68103-2271. I realize that my right to revoke this authorization is limited to the extent that Gerber Life Insurance Company has taken action in reliance on the authorization or the law allows Gerber Life Insurance Company to contest the issuance of the policy or a claim under the policy.
- "Personal Information" means all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. 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 Gerber Life Insurance Company.

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** and an Outline of Coverage.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

✍ Dated at _____, on ☐☐/☐☐/☐☐☐☐ _____

City State Month Day Year Applicant A's Signature

✍ Dated at _____, on ☐☐/☐☐/☐☐☐☐ _____

City State Month Day Year Applicant B's Signature (if applying)

T03-2015-08

I. Producer Comments (please attach a separate sheet if needed)

J. To be Completed by Producer

19. Producers shall list any other health insurance policies/certificates they have sold to the applicant.
(a) List policies/certificates sold to the applicant which are still in force.

Applicant A
Applicant B

(b) List policies/certificates sold to the applicant in the past five (5) years which are no longer in force.

Applicant A
Applicant B

I/We certify as follows:

I/We have provided a copy of the replacement notice if the applicant is replacing coverage..... ☐ Y ☐ N

I/We have accurately recorded in the application the information supplied by the applicant..... ☐ Y ☐ N

I/We certify that we have interviewed the proposed applicant..... ☐ Y ☐ N

If you answered "NO" to any of the above statements, please explain why. _____

_____

✍ _____
Signature of Licensed Producer Date

_____
Printed Name

_____
Florida License Identification Number

Agent Writing Number

✍ _____
Signature of Licensed Producer Date

_____
Printed Name

_____
Florida License Identification Number

Agent Writing Number

T03-2015-08

METHOD OF PAYMENT FORM — REQUIRED FORM – PLEASE RETURN

Part I . Select Premium Payment Option

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

Part II. Payor Information

Complete the following if premium is NOT paid by applicant (includes spouse or joint-married account):	Applicant A	Applicant B
1. **Account Owner Name**, if different than applicant's.....	_____	_____
2. **Account Owner Relationship** to applicant:		
Living Trust	☐	☐
Power of Attorney or legal guardian (documentation required)	☐	☐
Business owned by applicant or applicant's spouse	☐	☐

Part III. Account Information

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

Can attach voided check here

Applicant A
Account Type (check one): ☐ Checking ☐ Savings

_____
Name of Financial Institution

☐☐☐☐☐☐☐☐☐
Routing Number (9 digits on lower left side of check)

☐☐☐☐☐☐☐☐☐☐☐☐
Account Number (Do NOT use Debit/Credit Card numbers)

_____
Name as Shown on Account

Applicant B ☐ Same account as Applicant A
Account Type (check one): ☐ Checking ☐ Savings

_____
Name of Financial Institution

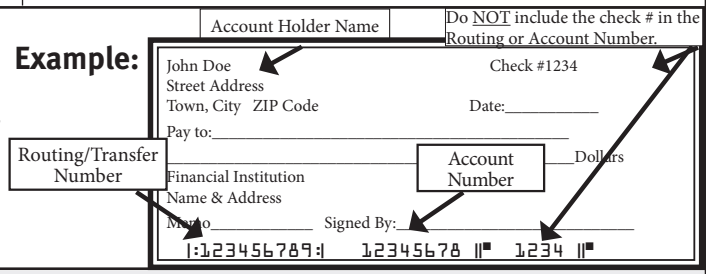
☐☐☐☐☐☐☐☐☐
Routing Number (9 digits on lower left side of check)

☐☐☐☐☐☐☐☐☐☐☐☐
Account Number (Do NOT use Debit/Credit Card numbers)

_____
Name as Shown on Account

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

Example:



IMPORTANT: When choosing to pay initial premium by Automated Bank Account Withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY. The first withdrawal date may be different from the monthly date selected for renewal premiums.
I authorize Gerber Life Insurance Company to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account to Gerber Life Insurance Company any preauthorized electronic fund transfers. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

✍	✍
Authorized Signature as Shown on Account	Authorized Signature as Shown on Account
Date	Date

T03_635

Gerber Life Insurance Company

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

Initial Premiums Paid through Automated Bank Account Withdrawal

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

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

Step 1 - Complete the Method of Payment form

For applicants wishing to pay electronically for either their **initial** or **renewal** premium(s), complete the entire Med supp *Method of Payment* form (T03_635), included in the application package:

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

1. Automated Bank Account Withdrawal fax transmittal cover sheet on the back of this form, T03_627
2. Med supp *Method of Payment* form, T03_635
3. Med supp application and other required forms

Tips for Submitting Initial Premiums through Automated Bank Account Withdrawal

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

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

T03_627

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

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

Gerber Life
Insurance Company

Fax

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

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

Please complete the following information:

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

Producer Name	Producer Number or SSN
Phone Number	Fax Number

Comments _____

_____

_____

_____

_____

_____

_____

T03_627

Gerber Life
Insurance Company

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

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

According to information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Gerber Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate you 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 Agent: I have reviewed your current medical and health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

Applicant	Applicant B
☐ Additional benefits	☐ Additional benefits
☐ No change in benefits, but lower premiums	☐ No change in benefits, but lower premiums
☐ Fewer benefits and lower premiums	☐ Fewer benefits and lower premiums
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D	☐ 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	☐ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
☐ Other (please specify)	☐ Other (please specify)
_____	_____
_____	_____
_____	_____

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 premium as to be certain that all information has been properly recorded. Do not cancel you 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 **Date**

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

Applicant	Applicant B
Signature ✍	Signature ✍
Date	Date

T03_202_FL

T03_202_FL

Gerber Life
Insurance Company

Certification

I, The Undersigned Insurance Agent Certify:

That, I have taken an application for Policy Form No. _____ offered by Gerber Life Insurance Company, to _____ .

That, I have explained the provisions of the Policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

That, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the Amount of $ _____ which has been paid to me by check money order credit card.

That, I have clearly explained that the benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

That, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Health Care Financing Administration of the Federal Government in connection with this insurance policy being applied for.

Signature of Agent _____ Date _____

Name of Agency _____ Phone No. _____

Address of Agent or Agency _____

I, The Undersigned Applicant, Have Received a Copy of This Form:

Signature of Applicant A _____ Date_____

Signature of Applicant B _____ Date_____

T03_215_FL

T03_215_FL

Gerber Life
Insurance Company

Medicare Select Policy Disclosure Agreement

I acknowledge receipt of the following information:

1. Outline of Coverage
2. Description of the restricted network provisions including:
   (a) network providers;
   (b) payments for coinsurance and deductibles when providers other than network providers are utilized;
   (c) coverage for emergency and urgently needed care and other out of service area coverage;
   (d) limitations on referrals to restricted network providers;
   (e) description of my rights to purchase a Medicare Supplement policy of equal or lesser benefits offered in my state by Gerber Life ;
   (f) Gerber Life Insurance Company's Quality Assurance Program; and
   (g) Gerber Life Insurance Company's Grievance Procedures.

I also understand the following:

Gerber does not recommend the purchase of a Medicare Select policy if I live more than 30 miles from a network hospital; unless the network hospital is the closest hospital which offers this level of service.

I have received full and fair disclosure of the information described above.

Signature of the Proposed Applicant	Signature of the Proposed Applicant B
Date	Date

T03_203_FL

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

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

Replacement Notice

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

Florida Certification

Premium Receipt / Notice of Information Practices

Gerber Life
Insurance Company

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

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

According to information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Gerber Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate you 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 Agent: I have reviewed your current medical and health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

Applicant	Applicant B
☐ Additional benefits	☐ Additional benefits
☐ No change in benefits, but lower premiums	☐ No change in benefits, but lower premiums
☐ Fewer benefits and lower premiums	☐ Fewer benefits and lower premiums
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D	☐ 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	☐ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
☐ Other (please specify)	☐ Other (please specify)
_____	_____
_____	_____
_____	_____

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 premium as to be certain that all information has been properly recorded. Do not cancel you 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 **Date**

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

Applicant	Applicant B
Signature ✍	Signature ✍
Date	Date

T03_202_FL

T03_202_FL

Gerber Life
Insurance Company

Certification

I, The Undersigned Insurance Agent Certify:

That, I have taken an application for Policy Form No. _____ offered by Gerber Life Insurance Company, to _____ .

That, I have explained the provisions of the Policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

That, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the Amount of $ _____ which has been paid to me by check money order credit card.

That, I have clearly explained that the benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

That, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Health Care Financing Administration of the Federal Government in connection with this insurance policy being applied for.

Signature of Agent _____ Date _____

Name of Agency _____ Phone No. _____

Address of Agent or Agency _____

I, The Undersigned Applicant, Have Received a Copy of This Form:

Signature of Applicant A _____ Date_____

Signature of Applicant B _____ Date_____

T03_215_FL

T03_215_FL

Gerber Life
Insurance Company

Premium Receipt

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

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

Applicant A

Received from _____

this _____ day of _____ , _____

an application for Form_____Policy

and/or Riders _____and

Check for _____Dollars.

✍ Agent _____

Applicant B

Received from _____

this _____ day of _____ , _____

an application for Form_____Policy

and/or Riders _____and

Check for _____Dollars.

✍ Agent _____

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

Notice of Information Practices

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

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

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

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

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

T03_364

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