LOYAL AMERICAN LIFE INSURANCE COMPANY®

11200 Lakeline Blvd., Suite 100, Austin, TX 78717

Mailing address: PO Box 559015, Austin, TX 78755-9015

Medicare Supplement Insurance and Whole Life Insurance Application

☐ NEW BUSINESS ☐ REINSTATEMENT **PV Case #**________________

Upon Your written request, We will provide to You, within 10 days, reasonable factual information regarding the benefits and provisions of this Policy. You can write to Us or call Us at the address and telephone numer listed above.

SECTION I: 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** ____________________

Social Security No.	Medicare Card No.	Sex M/F	Height Ft.	In.	Weight Lbs.
– –					

Have you used tobacco within the last 12 months? ☐ Yes ☐ No **Rate Class:** ☐ Preferred ☐ Standard

SECTION II: BILLING

METHOD (select one of the following):
☐ Bank Draft (complete the EFT Agreement)
☐ Direct Bill

MODE (select one of the following):
☐ Monthly (n/a with Direct Bill) ☐ Quarterly
☐ Semi-annually ☐ Annually

SECTION III: MEDICARE SUPPLEMENT COVERAGE APPLIED FOR

Requested Effective Date __________ *(if no date, we will assign the 1st day of the month following the Application date)*

Application is for: ☐ Underwritten ☐ OE ☐ GI

Check Plan selected: ☐ Plan A ☐ Plan F ☐ Plan G ☐ Plan N **Modal Premium** $________

SECTION IV: WHOLE LIFE COVERAGE APPLIED FOR

If you are in Open Enrollment or eligible for Guaranteed Issue of a Medicare Supplement policy and are applying for Whole Life Insurance, you must answer all of the questions in Section IX of the application.

Requested Effective Date __________ *(if no date, we will assign the 1st day of the month following the Application date)*

Whole Life Insurance: Benefit Amount $________ **Policy Modal Premium*** $________
*Modal Premium includes a $36 annual policy fee

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship

Owner, if other than the Proposed Insured Name	Relationship	Social Security No.
		– –
Address		

SECTION V: TOTAL PREMIUM WITH APPLICATION

Initial premium*: ☐ Draft bank account ☐ Check enclosed (payable to ***Loyal American Life Insurance Company)***
*initial premium payment must include the Medicare Supplement one-time enrollment fee

Medicare Supplement Policy Modal Premium	$________
Whole Life Insurance Policy Modal Premium	$________
One-time Enrollment Fee*	$ 20
Total Premium with Application	$________

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

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 (mark YES or NO below with an "X").

To the best of your knowledge, **YES NO**

1) a) Did you turn age 65 in the last 6 months? ☐ ☐
   b) Did you enroll in Medicare Part B in the last 6 months? ☐ ☐
   If "YES", what is the effective date? ____________

2) 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.) ☐ ☐
   If "YES",
   a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ ☐
   b) Do you receive any benefits from Medicaid ***other than*** payments toward your Medicare Part B premium? ☐ ☐

3) Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO)? ☐ ☐
   If "YES",
   a) Fill in your "START" and "END" dates below (if you are still covered under this plan, leave "END" date blank): 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? ☐ ☐
   c) Was this your first time in this type of Medicare plan? ☐ ☐
   d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ ☐

4) a) Do you have another Medicare Supplement policy in force? ☐ ☐
   b) If so, with what company and what type plan do you have? ____________
   ____
   c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ ☐
   If existing Medicare Supplement coverage is not to be replaced, this policy cannot be issued.

5) Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ☐ ☐
   a) If so, with what company and what kind of policy? ____________
   ____
   b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave the "END" date blank.) START ____________ END ____________

SECTION VII: MEDICARE

1) Do you now have Medicare Parts A and B? **YES** ☐ **NO** ☐
   If "YES", give effective date of Part B ____________

2) If Medicare Parts A and B are to be effective at a future date, provide the date both Medicare Parts A and B will be effective ____________
   NOTE: Medicare effective date is always the 1st day of the month. Applicant must have both Medicare Parts A and B on the effective date of the policy. If not, coverage cannot be issued.

SECTION VIII: EXISTING COVERAGE & REPLACEMENT (IF APPLYING FOR WHOLE LIFE INSURANCE, PLEASE COMPLETE THIS SECTION)

1) Do you, the Applicant, have existing individual life insurance policies or individual annuity contracts with this or any other company? .... YES ☐ NO ☐

If "YES", (a) the Applicant and Agent must complete the required "Important Notice: Replacement of Life Insurance or Annuities" form; (b) the Agent must complete the Section "Agent Provided Sales Material Statement" below and sign; and (c) provide the following information (use additional sheet, if needed):

Insurance Company Name and Address	Contract or Policy Number	Is Coverage being Replaced?
		YES ☐ NO ☐
		YES ☐ NO ☐

Applicant's Signature / Printed Name __________ Date __________

Agent's Signature / Printed Name __________ Date __________

2) **AGENT PROVIDED SALES MATERIAL STATEMENT (MUST BE COMPLETED BY THE AGENT ONLY IF THE APPLICANT IS REPLACING EXISTING LIFE INSURANCE OR ANNUITY)**: I hereby certify that in connection with my presentation to the Applicant herein, I only used sales material that was previously approved by Loyal American Life Insurance Company and that I left with or provided to the Applicant a copy of the sales material used in my presentation to the Applicant.

Agent's Signature / Printed Name __________ Date __________

SECTION IX: MEDICAL QUESTIONS

FOR MEDICARE SUPPLEMENT: If you are in Open Enrollment or eligible for Guaranteed Issue (based on your answers in Sections VI & VII), DO NOT ANSWER the questions in this section.

IF APPLYING FOR WHOLE LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS IN 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. 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.

PART A: MEDICAL QUESTIONS - If the answer to any question in Part A is "YES", the Applicant is not eligible for coverage.

	YES	NO
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)?	☐	☐
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 the following conditions:		
a) hepatitis (other than hepatitis A), cirrhosis of the liver, or other liver disease?	☐	☐
b) major depression, bipolar disorder, schizophrenia, or a paranoid disorder?	☐	☐
c) diabetes requiring more than 50 units of insulin daily to control or diabetes with any of the following: neuropathy, retinopathy, vascular disease, or hypertension requiring more than two medications to control?	☐	☐
d) chronic kidney disease, Addison's Disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant?	☐	☐
e) internal cancer, leukemia, malignant melanoma, Hodgkin's Disease, or lymphoma?	☐	☐

	YES	NO
f) alcohol or drug abuse?	☐	☐
g) paralysis, hemophilia, osteoporosis with fractures, or unrepaired aneurysm?	☐	☐
h) Paget's Disease, rheumatoid or disabling arthritis, systemic lupus, or other connective tissue disorder?	☐	☐
6) Do you have now or at any time have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions:		
a) Parkinson's Disease, myasthenia gravis, multiple or amyotrophic lateral sclerosis (Lou Gehrig's Disease), muscular dystrophy, cerebral palsy, dementia, senility, Alzheimer's Disease, or organic brain disorder?	☐	☐
b) emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic Obstructive Lung Disease (COLD), or any chronic lung or respiratory disorder requiring the use of oxygen?	☐	☐
c) amputation caused by disease or organ transplant other than corneas?	☐	☐
7) Have you ever been diagnosed with or received medical advice or treatment from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection?	☐	☐
8) 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?	☐	☐
9) Has surgery been advised but not performed or is any surgery anticipated, including but not limited to joint replacement or cataract surgery?	☐	☐
10) 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 - If the answer to any of the following questions is "YES", you might be eligible for coverage. Please provide complete details as requested below.

	YES	NO
11) 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:

____

____

	YES	NO
12) 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

	YES	NO
13) 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: MEDICATIONS

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

Medication	Dates Taken	Condition Taken for

AGENT NOTES - Please provide any other information that you believe may assist in our underwriting determination:

____

____

____

____

SECTION X: IMPORTANT STATEMENTS FOR APPLICANT TO READ

- 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 coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing this 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).

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 ______________________

I understand that the Medicare Supplement policy applied for will not cover loss due to Preexisting Condition(s) unless the expense for that loss is incurred more than six (6) months after the effective date of coverage.

Applicant's Printed Name ______________________________

Signature of Applicant ______________________________ Date ______________

SECTION XI: AGENT(S) CERTIFICATION

Agent(s) 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.	☐	☐

______

______

	YES	NO
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 certify 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.

______	______	______	______
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 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

Signature of Consumer **Date**

Signature of Company's Agent **Date**

Name of Consumer's Personal Representative, if applicable

Relationship of Personal Representative to the Consumer

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

Loyal American Life Insurance Company®

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

Notice and Customer Information Form

To help the government fight the funding of terrorism and money laundering activities, Federal law requires us to obtain all relevant customer-related information necessary to run an effective anti-money laundering program.

What this means to you: When submitting an application/order ticket/request form, we ask that the producer obtain the client's name, street address, date of birth, tax identification number, and other customer-related information that will allow us to identify the customer and fulfill our obligations under Federal law. Picture documentation, such as a driver's license or other identifying documents, will be used to verify the information given at the time of the sale.

By acknowledging receipt of this Notice and Customer Information Form, the undersigned authorizes any law enforcement agency, public or private institution, information service bureau, or other entity contacted by the Company identified above to furnish information sufficient to confirm the personal information of the undersigned as required by Federal law. This information is confidential and will not be used for any other purpose. The undersigned hereby releases all persons, agents and agencies, and entities providing confirming information from any and all liability arising out of the request for or the release of confirming information.

The owner information section must be completed in its entirety. If identification documents are not available, the customer must sign the form and the information will be verified by the Company.

The following information must be obtained for each tax identification number or social security number disclosed on the application for insurance.

I. **Owner**

FEIN/SSN	**Owner Name**	**Verification of ID** ☐ Driver's License/State ID ☐ Passport ☐ Other ______ ☐ Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)	**State/Country**	
Date of Birth	**Occupation**		**Number**	
Employer			**Date Issued**	**Exp. Date**

Additional Owner

FEIN/SSN	**Person's Name**	**Verification of ID** ☐ Driver's License/State ID ☐ Passport ☐ Other ______ ☐ Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)	**State/Country**	
Date of Birth	**Occupation**		**Number**	
Employer			**Date Issued**	**Exp. Date**

II. The source of funds for this transaction is ______

III. The purpose of this transaction is ______

Agent: I have examined and verified the customer's ID as noted above is true and correct to the best of my knowledge and belief.

______ Agent's Printed Name ______ Agent Number

______ Agent's Signature ______ Date

-------------- **COMPLETE THIS PORTION ONLY IF THE APPLICANT DOES NOT HAVE IDENTIFICATION DOCUMENTS** --------------

Customer(s): I acknowledge the foregoing notice and certify that the foregoing information is true and correct to the best of my knowledge and belief.

______ Owner's Printed Name ______ Owner's Signature Date

______ Additional Owner's Printed Name ______ Additional Owner's Signature Date

LOYAL AMERICAN LIFE INSURANCE COMPANY®

PO Box 559015, Austin, TX 78755-9015 • Toll Free: 866-459-4272

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the Applicant and the Producer (if there is one) and a copy left with the Applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy or contract and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1) Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? .... YES ☐ NO ☐

2) Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? .... YES ☐ NO ☐

If you answered "YES" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT/POLICY NUMBER	INSURED OR ANNUITANT	REPLACED (R) / FINANCED (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because ____

I certify that the responses herein are accurate, to the best of my knowledge:

____ ______________________

Applicant's Signature and Printed Name **Date**

____ ______________________

Producer's Signature and Printed Name **Date**

I do not want this notice read aloud to me. __________ (Applicant: Initial only if you do not want the notice read aloud.)

A replacement may not be in your best interest or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
- Are they affordable?
- Could they change?
- You're older – are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? on the old policy?

POLICY VALUES:
- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:
- If your health has changed since you bought your old policy, the new one could cost you more or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST-SENSITIVE LIFE PRODUCT:
- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?