"Serving you
- since '32"

OLD SURETY LIFE

INSURANCE COMPANY
P.O. BOX 54407 - OKLAHOMA CITY, OK 73154-1407
405-523-2112
Toll Free # 1-800-272-5466

Medicare Supplement Application

* * * 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.

* This Application Must be Submitted in its Entirety
- DO NOT REMOVE ANY PAGES -

* A voided check must be obtained if you are applying for a monthly bank draft.

For Use in the State of NEBRASKA Only

Supplement to Application for Medicare Supplement Insurance

Guaranteed Issue Eligible persons are those individuals described below who apply to enroll under the policy not later than 63 days after the date of the termination of enrollment and who submit evidence of the date of termination or disenrollment.

Eligible Persons An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan (group insurance) that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan (group insurance) that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.

(2) The individual enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of all-inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual enrolled in a Medicare Advantage plan:

(A) The certification of the organization or plan has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or
(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuance of such plan; or
(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851 (g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856, or the plan is terminated for all individuals within a residence area); or
(D) The individual demonstrates, in accordance with guidelines established by the Secretary, that (i) the organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or (ii) the organization, agent or other entity acting on the organization's behalf, materially misrepresented the plan's provision in marketing the plan to the individual; or
(E) The individual meets such other exceptional conditions as the Secretary may provide.

(3) The individual is enrolled with an entity listed in subparagraphs (A) – (D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 3.3312 (b)(2) of this title relating to Guaranteed Issue for eligible persons:

(A) An eligible organization under a contract under Section 1876 (Medicare risk or costs); or
(B) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999; or
(C) An organization under an agreement under Section 1833 (a)(1)(A) (health care prepayment plan); or
(D) An organization under a Medicare Select policy.

(4) The individual is enrolled under a Medicare Supplement policy and the enrollment ceases because:

(A) Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or of other involuntary termination of coverage or enrollment under the policy; or
(B) The issuer of the policy substantially violated a material provision of the policy; or
(C) The issuer, or an agent or other entity acting on the issuer's behalf materially misrepresented the policy's provision in marketing the policy to the individual.

Supplement to Application for Medicare Supplement Insurance
(continued)

(5) The individual was enrolled under a Medicare Supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract under Section 1876 (Medicare risk or cost), any similar organization operating under demonstration project authority, any PACE organization operating under Section 1894 of the Social Security Act, any organization under an agreement under Section 1833 (a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under Section 1851 (e) of the Social Security Act).

(6) The individual, upon first becoming enrolled in Medicare Part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under Medicare Part C, or in a PACE program under Section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare Supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.

(8) The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

IMPORTANT ADDITIONAL INFORMATION FOR APPLICANT TO READ

(a) You do not need more than one Medicare Supplement policy. (b) 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. (c) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. (d) 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 up to 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 suspension. (e) 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 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. (f) 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).

PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

1. Have you used any form of tobacco (including vaping or e-cigarettes) in the past 24 months? Yes___ No___

2. Are you applying during an "Open Enrollment" or a "Guaranteed Issue" period? Yes___ No___
   (If Yes, please attach proof of eligibility for **Guaranteed Issue only**).

MEDICARE AND INSURANCE INFORMATION (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 OF THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. Please mark YES or NO to each question below with an "X".**

1. Did you turn age 65 in the last 6 months? Yes___ No___
2. Did you enroll in Medicare Part B in the last 6 months? Yes___ No___
   If Yes, what is the effective date? ____/____/_____
3. Are you covered for medical assistance through the state Medicaid program? Yes___ No___
   [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? Yes___ No___
   (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes___ No___
4. If 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), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
   START ____/____/_____ END ____/____/_____
   If Yes, with which company _____
   Policy Number _____
   (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 in this type of Medicare plan? Yes___ No___
   (c) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes___ No___
   (d) If so, with which company?_____
   and what plan did you have?_____
5. Do you have another Medicare Supplement policy in force? Yes___ No___
   (a) If Yes, with which company?_____
   Policy number_____Plan type_____
   (b) If so, do you intend to replace your current Medicare Supplement policy with this policy if issued? Planned Termination Date ____/____/_____ Yes___ No___
6. Have you had coverage under any other health insurance within the past 63 days?
   (For example, an employer, union or individual plan.) Yes___ No___
   (a) If so, with which company and what kind of policy? _____
   (b) What are your dates of coverage under the other policy?
   If you are still covered under this policy, leave "END" blank.
   START____/____/_____ END____/____/_____

_____ ____/____/_____

Applicant's Signature **Date**

**** IMPORTANT * This application is for residents of NEBRASKA only.***

MEDICARE SUPPLEMENT APPLICATION to OLD SURETY LIFE INSURANCE COMPANY

MODEL PLAN (*check one*)	PAYMENT MODE (*check one*)	BILLING MODE (*check one*)	MAILING PREFERENCE (*check one*)
Plan A ☐ Plan F ☐ Plan G ☐	Mail ☐ Bank Draft ☐	Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐	Mail policy to: Agent ☐ Insured ☐

Standard rates YES ☐ NO ☐ Mode Premium $ _____ Policy Fee $ $ 20.00 TOTAL $ _____	Requested Draft Date: The_____of each month Requested Effective Date: _____

Proposed Insured	Sex	Birthdate **Month / Day / Year**	Age	Height	Weight

Residence Address	**Number**	**Street**	**City**	**State**	**Zip**
Mail Address if other than residence					

Home Phone	Cell Phone	E-mail

Premium Payor if other than proposed insured	**Name**	**Address**

Are you currently covered by Medicare Part A & Part B? Yes ☐ No ☐	List Medicare Eligibility Dates: Part A:_____/_____/_____ Part B:_____/_____/_____	Medicare Claim #: _____ SSN #

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If applying during Open Enrollment or a Guaranteed Issue scenario, you are not required to answer questions 1-15.

NOTICE TO APPLICANT: PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS in the Health Questions Sections. If any question in Section 1 is answered "YES", the applicant is not eligible for coverage. If any question(s) in Section 2 is answered "YES", the applicant may be eligible for coverage. Please verify the accuracy and completeness of the health information on this application. Incomplete or false information could jeopardize future claims.

HEALTH QUESTIONS SECTION # 1

…….IF ANY QUESTION 1-8 IS ANSWERED "YES", THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE…….

1. Are you currently:

A. Hospitalized confined to a nursing facility, bedridden or require the use of a wheelchair or motorized mobility aid? YES ☐ NO ☐

B. Receiving hospice, home health care or physical therapy? YES ☐ NO ☐

2. Have you ever been medically diagnosed or treated for diabetes:

A. That requires insulin or more than (**2**) two oral medications? YES ☐ NO ☐

B. With history of heart attack, stroke or any kidney disease? YES ☐ NO ☐

C. With complications including retinopathy, neuropathy or peripheral vascular disease? YES ☐ NO ☐

3. If you have diabetes in conjunction with high blood pressure, have there been any changes or adjustments in your medications because of uncontrolled blood sugar in the past 24 months? YES ☐ NO ☐
(If you do not have diabetes this question should be answered **"NO"**)

4. Have you ever had or been advised to have any bone marrow transplant, stem cell transplant, an organ transplant or any amputation caused by disease? YES ☐ NO ☐

5. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:

A. Alzheimer's disease, senile dementia, or any other cognitive disorder? YES ☐ NO ☐

B. Emphysema, chronic obstructive pulmonary disease (COPD), sarcoidosis, or any pulmonary condition treated with supplemental oxygen or a nebulizer? YES ☐ NO ☐

C. Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (Lou Gehrig's disease), muscular dystrophy or cerebral palsy? YES ☐ NO ☐

D. Lupus, scleroderma, myasthenia gravis or Paget's disease? YES ☐ NO ☐

E. Osteoporosis with fracture(s), crippling/disabling arthritis or rheumatoid arthritis? YES ☐ NO ☐

F. Chronic hepatitis, cirrhosis of the liver, Crohn's disease or ulcerative colitis? YES ☐ NO ☐

G. Retinopathy, wet macular degeneration or any eye condition that required injection(s)? YES ☐ NO ☐

H. Addison's disease, Hodgkin's Disease, kidney failure or ever had kidney dialysis? YES ☐ NO ☐

I. Congestive heart failure or a cardiac defibrillator? YES ☐ NO ☐

J. Lymphoma, leukemia, multiple myeloma or more than (1) one occurrence of internal cancer? YES ☐ NO ☐

K. Acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV) infection? YES ☐ NO ☐

6. Within the past (5) five years, have you been treated for, or been advised to have treatment for;

A. Hepatitis C, alcoholism, drug abuse, or had a mental or nervous disorder requiring a hospital confinement? YES ☐ NO ☐

B. Any condition that resulted in chemotherapy or radiation treatments? YES ☐ NO ☐

C. Osteopenia, Osteoporosis or any Arthritic condition whereas treatment included infusions(s) or injection(s)? YES ☐ NO ☐

7. Within the past (2) two years, have you been treated for, or been advised to have treatment for:

A. Heart attack, cardiomyopathy, an enlarged heart, Stroke or transient ischemic attack (TIA)? YES ☐ NO ☐

B. Coronary bypass surgery, heart valve surgery, aneurysm, angioplasty, or vascular surgery including stent(s) placement and or artery blockage? YES ☐ NO ☐

C. Heart rhythm disorder, Atrial fibrillation (AFIB) or have you had a pacemaker implanted? YES ☐ NO ☐

D. Any form of Internal cancer or melanoma? YES ☐ NO ☐

HEALTH QUESTIONS SECTION # 1 (continued)

8. Within the past (3) three years, have you been advised by a medical professional to have any:

A. Treatment(s), further evaluation, diagnostic testing, or surgery that has not been performed or do you have pending test results? YES ☐ NO ☐

B. Cataract surgery which has not been performed or which is anticipated in the next 12 months? YES ☐ NO ☐

HEALTH QUESTIONS SECTION # 2

……IF ANY QUESTION 9-15 IS ANSWERED "YES", YOU MAY BE ELIGIBLE FOR COVERAGE……

Consideration will be based on information obtained in conjunction with medications and treatments for any and/or all conditions listed below.

9. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:

A. Heart attack, angioplasty, aneurysm, any type of heart or vascular surgery including stent(s), artery blockage, heart rhythm disorders (AFIB) or had a pacemaker implanted? YES ☐ NO ☐

B. Stroke or transient ischemic attack (TIA) YES ☐ NO ☐

C. Any form of Internal cancer, melanoma or blood disorder? YES ☐ NO ☐

D. Chronic Kidney disease or do you have only one Kidney? YES ☐ NO ☐

10. Do you have asthma or any non-chronic pulmonary condition which requires the use of medications, including inhalers? YES ☐ NO ☐

11. Within the past (3) three years have you had any infusions, injections, or transfusions in a medical facility or are any anticipated in the next 12 months (excluding vaccinations)? YES ☐ NO ☐

12. Within the past (2) two years, have you had ***any*** surgeries, physical therapy, or joint replacements? YES ☐ NO ☐
(If YES, you must be fully released from physician for a period of more than 60 days for consideration)

13. Within the past (2) two years, have you been hospitalized, under observation care in a hospital, or have you received treatment in an Emergency Room for any reason? YES ☐ NO ☐

List any other significant diseases or disorders not listed above

Please explain any "YES" answer(s) for questions 9-13 including condition treated, treatment method, beginning and end dates of treatment, etc..

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

HEALTH QUESTIONS SECTION # 2 (continued)

14. Are you taking or have you taken any prescription medications within the past **24 months**?
If YES, please list the information below for each medication. (attach a separate sheet if needed) YES ☐ NO ☐

	Medication Name	
	Dosage and Frequency	
	Diagnosis/Medical Condition	
	Date Originally Prescribed	

	Medication Name	
	Dosage and Frequency	
	Diagnosis/Medical Condition	
	Date Originally Prescribed	

	Medication Name	
	Dosage and Frequency	
	Diagnosis/Medical Condition	
	Date Originally Prescribed	

	Medication Name	
	Dosage and Frequency	
	Diagnosis/Medical Condition	
	Date Originally Prescribed	

Please provide complete name, address and telephone number of the proposed insured's primary care physician:

Physician's Name_____Telephone (_____)_____

Address_____City_____State_____Zip_____

Date last seen _____Reason_____

Please provide name(s) of any other physicians or specialists you have visited in the past (24) twenty-four months:

Name_____(specialty)_____

Date last seen _____Reason_____

Name_____(specialty) _____

Date last seen _____Reason_____

Name_____(specialty)_____

Date last seen _____Reason_____

15. Have you seen any additional physicians other than those listed above in the past 24 months? YES ☐ NO ☐

AUTHORIZATION AND AGREEMENT

Authorization for the Release of Personal Health Information to OLD SURETY LIFE INSURANCE COMPANY
This authorization complies with the **HIPAA** Privacy Rules.

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, health care provider, health plan, insurer, and/or any entity subject to the **Health Insurance Portability and Accountability Act** of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to **Old Surety Life Insurance Company("OSLIC")** and its agents, employees and representatives. This includes all information relating to my health (except psychotherapy notes) and, including but not limited to, hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of human immunodeficiency virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, health care provider, health plan, insurer and/or any entity subject to HIPAA to release and disclose such information without restriction.

My protected health information is to be disclosed under this authorization so that OSLIC may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, or have applied for with OSLIC.

For a period of 120 days from the date of this authorization, I authorize my OSLIC producer to receive certain protected health information about me that is related to an adverse underwriting decision made during the underwriting of my application or that is related to administer claims and determine or fulfill responsibility for coverage and provision of benefits.

This authorization shall remain in force for (24) twenty-four months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time, by sending a written request for revocation to: OSLIC at PO BOX 54407, OKC OK 73154, Attention Underwriting Department. I understand that a revocation is not effective to the extent that any of my providers has already relied on this authorization or to the extent that OSLIC has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand any information disclosed under this authorization may no longer be covered by Federal rules governing privacy and confidentiality of health information and may be subject to disclosure. I understand that I am entitled to receive a copy of this authorization.

I understand that if I refuse to sign this authorization to release my complete medical record, OSLIC may not be able to process my application for insurance, or if coverage has been issued may not be able to make any benefit payments.

I wish to apply for Medicare Supplement insurance coverage. I acknowledge that I have received or have been given access to review: (a) an Outline of Coverage for the coverage applied for, and (b) a "Guide to Health Insurance for People with Medicare."

I understand that if my policy is issued during my open enrollment period, it will contain up to a (6) six month waiting period on pre-existing conditions unless I provide proof I am replacing creditable coverage. If I qualify as an eligible person, any waiting period will be waived for the period of time creditable coverage was provided.

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this application. To the best of my knowledge and belief they are true and complete. I understand the Company may conduct a telephone interview with me regarding the answers. I understand if my answers are incorrect or untrue, the Company has the right to deny benefits or rescind my coverage. I understand the insurance applied for will not become effective until the policy is issued and actually delivered to the owner while the proposed insured is in the same condition of health as described in the foregoing application and the first premium has been paid.

_____

Printed Name of the Proposed Insured **Date of Birth** **Social Security #**

Dated at _____ **on** _____

City State Date

_____

SIGNATURE OF THE PROPOSED INSURED

AUTHORIZATION AND AGREEMENT (Continued)

THE AGENT IS TO ANSWER THE FOLLOWING:

1. Have you sold any other health insurance policies of coverages to this applicant which are still in force? Yes___ No___

   If Yes, list all such coverage _____

2. Have you sold any other health insurance policies or coverages to this applicant in the past (5) five years which are no longer in force? Yes___ No___

   If Yes, list all such coverage _____

I certify that:

1) I asked the proposed insured the questions in the application and truthfully and accurately recorded their answers; 2) their answers did not conflict with my observations and/or knowledge of the proposed insured; and 3) they received or have been given access to the Outline of Coverage & Guide to Health Insurance for People with Medicare.

Agent Name _____ **Agent Writing Number**_____

Agent Signature _____ **Date**_____

List any additional information or comments here.

AGENT REQUEST TO SPLIT COMMISSION

Yes____ No ____

If this application results in an issued policy, the agents listed below have agreed to split the commissions earned on the policy. Both agents must be properly licensed and appointed with OSL in the policy's state of issue. Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force. Percentage of premium split must be whole numbers and total 100%. Calculation of each agent's commissions is based on their respective OSL commission schedule.

Writing Agent Name _____ **Percentage** _____**%**

Writing Agent Signature _____

Secondary Agent Printed Name _____

Secondary Agent OSL Writing Number _____ **Percentage** _____**%**

This section must be completed with the application in order to split commissions. By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE or MEDICARE ADVANTAGE

OLD SURETY LIFE INSURANCE COMPANY 5201 N. Lincoln - P. O. Box 54407, Oklahoma City, OK 73154

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 Old Surety Life Insurance Company. Your new policy will provide (30) thirty days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. 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 AGENT

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy (if issued) will not duplicate your existing Medicare Supplement coverage 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(s): (*please check one*)

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

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

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.

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 to the extent such time was spent under the original policy.

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 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 that you want to keep it.

_____

Signature of Agent, Broker or Other Representative **Date**

_____

Type or print name and address of Agent or Broker

_____

Print Applicant's Name

_____

Applicant's Signature **Date**

PREMIUM PAYOR AUTHORIZATION AGREEMENT FOR PRE-ARRANGED PAYMENTS (DEBITS)
(Please attach a voided check)

I hereby authorize **Old Surety Life Insurance Company** to debit / charge my account indicated below.

Checking Account	Saving Account	9 digit Bank **ROUTING** number	Bank **ACCOUNT** number
☐	☐	_____	_____

Bank Name:_____

Bank Address:_____

This authority is to remain in force and effect until the Company has received written notification from me of its termination in such time and in such manner as to afford Company a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notification to Company prior to charging account. The customer has the right to return an item up to 60 days after the charge date if the customer feels that the transaction was not authorized or if the customer is revoking the authorization. In the case of ACH or electronic funds transfer, Old Surety Life Insurance Company indemnifies the receiving financial institution through the National Automated Clearing House Association and local Automated Clearing House Association rules.

_____ _____

Signature **Print Premium Payor Name**

_____

Date

To: The Bank named above:
So that you may comply with your depositor's request, this Company agrees:

1. To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of pre-authorized check plan payment, including any costs or expenses reasonably incurred in connection therewith.
2. In the event that any such check, draft, or order shall be dishonored whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
3. To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing request, or in any manner arising by reason of your participation in the foregoing plan.

DALE L. PHILLIPS, President

OLD SURETY LIFE INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA
Authorized in a resolution adopted by the Board of Directors of the Old Surety Life Insurance Company, Oklahoma City, Oklahoma on July 27, 1998.

Attach a VOIDED check here.