

ASSURED LIFE ASSOCIATION

A Fraternal Benefit Society

P.O. Box 2397

Omaha, Nebraska 68103-2397



ASSURED LIFE
ASSOCIATION

Application Submission Checklist To Assured Life Association For Medicare Supplement or Select Coverage – OHIO

THIS APPLICATION MUST BE USED TO WRITE ASSURED LIFE ASSOCIATION MEDICARE SUPPLEMENT/ SELECT PRODUCTS

- Application**
 1. Complete “Plan Information” Box.
 2. Refer to the Outline of Coverage for certificate forms.
 3. Answer all questions in full.
 4. Sign and Date in all places indicated.
 5. Be sure to leave all applicable forms with the proposed insured.
 6. See reverse side of this page for additional detailed information.
- Collect Premium Amount**
 - The full modal premium is collected at the time of application.
 - Follow instructions on page 1 of **Calculate Your Premium form (T01_11)** to calculate the premium. Complete the form and return with the application.
 - Calculate the premium based on age at the time of application.
 - There will be fraternal membership dues (\$1.00 per month) added to your premium.
 - There is a one-time application fee of \$25.00 that will be collected with the initial payment.
- Provide Client with Buyer’s Guide**
- Provide Client with Outline of Coverage**
- Complete Producer Information page**
- If applicable, complete the Authorization for Electronic Funds Transfer form (ACH/BSP form T01_13) and return with the completed application**
- Provide Client with Conditional Receipt signed by agent (if applicable), and provide Client with Notice of Information Practices**
- Complete, sign and provide client with copy of the Authorization To Disclose Personal Information (HIPAA form T01_15). This form is NOT a requirement if applying during an Open Enrollment or Guaranteed Issue Period**
- Complete Replacement Notice (T01_49_OH) and leave a copy with the applicant (if applicable)**
- Complete Medicare Select Certificate Disclosure Agreement (T01_31) (if applicable)**

**Please provide additional information and comments
in the space provided on the application.**

Note: An interviewer may call to verify/confirm the information provided on the application.

There are two parts to this application: One part is the general application. The other part includes necessary administrative forms that you will need at time of sale.

1. Application – Agent Completes in Full: (please print)

“Plan Information” Box

- Certificate Form
 - Requested Effective Date
 - Premium Collected (Amount) - Follow instructions on page 1 of Calculate Your Premium form (T01_11) to calculate the premium. Complete the form for Applicants A & B (if applying) return with the application.
 - Initial Mode* (A=Annual, S=Semiannual, Q=Quarterly, B=Automatic Funds Withdraw, or ACH=Automatic Clearing House)
 - Renewal Premium (Amount)
 - Renewal Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Automatic Funds Withdraw)
- *Direct Monthly billing not available.

Section 1 “General Information”

- The Residence address and ZIP code are indicated. Alternate address for billing as indicated (when applicable).
- The applicant’s current age at time of application.
- The applicant’s Social Security number as indicated from applicant’s Social Security Card.
- For applicants already covered by Medicare, include applicant’s Medicare number on the application as indicated from the applicant’s Medicare Health Insurance Card. 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 1-877-223-4244 once it is received.
- The applicant’s current Height in feet and inches and Weight in pounds.

Sections 2 and 3 “Existing Coverage Information”

- Please complete all questions in full.
- If the applicant is not covered by Medicare, indicate “Eligibility Date” and “Date of Enrollment”.
- List all individual and group health policies/certificates held by the applicant in the appropriate section of the application.
- If the applicant is replacing current coverage with this certificate, indicate the following information.
 - Name of Company
 - Issue Date
 - Policy/Certificate Number
 - Termination/Disenrollment Date
 - Plan
 - Kind of Policy/Certificate

NOTE: An interviewer may call to verify/confirm the information provided on the application.

2. Administrative Forms

Producer/Agent Information

- Be sure to include your Social Security number and commission code.
NOTE: This information is necessary for the underwriting process and commission payment.
- Include your telephone number, e-mail address and FAX number for contact purposes.

Authorization for Electronic Funds Transfer by Assured Life Association (ACH/BSP) –

If applicant chooses to pay premium by ACH/BSP, complete this form accurately and in its entirety and return with the application.

- **Option A** - Pay all premiums (1st & monthly renewals) by ACH/BSP - DO NOT submit a check for payment.
- **Option B** - Pay 1st month by paper check & monthly renewals by BSP - A check for initial monthly premium MUST be submitted with the application.
- **Option C** - Pay 1st month by ACH & pay renewals by direct bill (monthly direct billing is not offered) - DO NOT submit a check for initial premium payment.

Conditional Receipt and Notice of Information Practices

- Complete and sign the receipt (if applicable), detach entire page and leave with applicant.

Authorization To Disclose Personal Information (HIPAA)

- If client is **NOT** applying during an Open Enrollment or Guaranteed Issue Period, completing the Authorization To Disclose Personal Information form **IS** a requirement. Please have the applicant read the form, fill in required information, sign, date and leave a copy of the completed and signed form with applicant.
- If client **IS** applying during an Open Enrollment or Guaranteed Issue Period, completing the Authorization To Disclose Personal Information form is **NOT** a requirement.

Replacement Notice – complete if applicable

- Complete form including signature and date.
- Leave a copy with applicant (if applicable).

State – Specific Forms – complete if applicable

- Be sure to include all state appropriate forms.

ASSURED LIFE ASSOCIATION
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Application For Medicare Supplement Coverage



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ASSOCIATION

PLAN INFORMATION (to be completed by Producer)			
<input type="checkbox"/> Plan A - MTA1	<input type="checkbox"/> Plan D - MTA4	<input type="checkbox"/> Plan B Select - MTA7	<input type="checkbox"/> Plan F Select - MTA10
<input type="checkbox"/> Plan B - MTA2	<input type="checkbox"/> Plan F - MTA5	<input type="checkbox"/> Plan C Select - MTA8	<input type="checkbox"/> Plan G Select - MTA11
<input type="checkbox"/> Plan C - MTA3	<input type="checkbox"/> Plan G - MTA6	<input type="checkbox"/> Plan D Select - MTA9	

NOTE: For ALL sections, ONLY complete the Applicant B information if to be insured.

APPLICANT	APPLICANT B
Certificate Form	Certificate Form
Requested Effective Date	Requested Effective Date
Premium Collected \$	Premium Collected \$
Initial Mode A, S, Q, B, ACH	Initial Mode A, S, Q, B, ACH
Renewal \$	Renewal \$
Renewal Mode A, S, Q, B (direct monthly not available)	Renewal Mode A, S, Q, B (direct monthly not available)

1. PLEASE READ THE FOLLOWING CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY.

Applicant	Applicant B
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address (if different from Applicant's)
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone No (_____) _____ (area code)	Home Phone No (_____) _____ (area code)
Current Age _____ Date of Birth ____/____/____ mo day yr	Current Age _____ Date of Birth ____/____/____ mo day yr
Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Social Security No	Social Security No
Medicare Health Insurance Card Number (if known)	Medicare Health Insurance Card Number (if known)
E-mail Address	E-mail Address
Height Weight Ft _____ In _____ Lbs _____	Height Weight Ft _____ In _____ Lbs _____

2. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

1. Have you received a copy of the Guide to Health Insurance for People with Medicare and the Outline of Coverage?	Applicant Yes <input type="checkbox"/> No <input type="checkbox"/>	Applicant B Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you used tobacco in any form in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A? If "YES," what is your Part A effective date? _____ / _____ / _____ Applicant / Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "NO," what is your eligibility date? _____ / _____ / _____ Applicant / Applicant B		
2. Are you covered under Medicare Part B? If "YES," what is your Part B effective date? _____ / _____ / _____ Applicant / Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "NO," indicate date you plan to enroll. _____ / _____ / _____ Applicant / Applicant B		
3. Did you turn age 65 in the last six months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Did you enroll in Medicare Part B in the last six months? If "YES," indicate your effective date. _____ / _____ / _____ Applicant / Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 certificate, or that you had certain rights to buy such a 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.**

3. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

To the Best of Your Knowledge:	Applicant	Applicant B
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES" please attach proof of eligibility.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force? (a) If "YES," with what company, and what plan do you have?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant	Applicant B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date ____ / ____ / ____	Issue Date ____ / ____ / ____

(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this certificate?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) If "YES," indicate termination date. _____ / _____ / _____ Applicant / Applicant B		
(d) If "YES," have you received a copy of the replacement notice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.		
3. 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 _____ / _____ / _____ Applicant / Applicant B		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement certificate?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) If "YES," have you received a copy of the replacement notice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) Reason for termination/disenrollment? _____ / _____ Applicant / Applicant B		
(d) Planned date of termination/disenrollment? _____ / _____ / _____ Applicant / Applicant B		

If you are applying during Open Enrollment or a Guaranteed Issue period, **SKIP SECTION 4 and GO TO SECTION 5.**

4. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. Make sure all questions are answered by each applicant. If either you or Applicant B answer "YES" to any of the following questions 1-14, that person is not eligible for coverage.

To the Best of Your Knowledge:	Applicant	Applicant B
1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. 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?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? If you do not have diabetes, this question should be answered "NO".	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Do you have diabetes that has ever required more than 50 units of insulin daily?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Within the past two years have you been treated for degenerative bone disease, crippling/ disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Have you been hospital confined three or more times in the last two years?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please list the drug and the condition in the following table.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant (please attach a separate sheet if needed)		Applicant B (please attach a separate sheet if needed)
_____	Medication Name (copy off pharmacy label)	_____
_____	Date Originally Prescribed	_____
_____	Frequency and Dosage	_____
_____	Diagnosis/Condition	_____
_____	Medication Name (copy off pharmacy label)	_____
_____	Date Originally Prescribed	_____
_____	Frequency and Dosage	_____
_____	Diagnosis/Condition	_____
_____	Medication Name (copy off pharmacy label)	_____
_____	Date Originally Prescribed	_____
_____	Frequency and Dosage	_____
_____	Diagnosis/Condition	_____

5. PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement certificate.
- If you purchase this certificate, 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 certificate.
- If, after purchasing the certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement certificate 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 certificate (or, if that is no longer available, a substantially equivalent certificate) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstated certificate 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 certificate 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 certificate can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement certificate under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement certificate (or, if that is no longer available, a substantially equivalent certificate) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstated certificate 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 wish to apply for a Medicare supplement insurance certificate. I represent that my answers and statements on this application are true and complete. I understand that, upon acceptance of the completed application, each applicant will receive a separate certificate. I understand that my certificate 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 Assured Life Association.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement is guilty of insurance fraud.

Dated at _____, on _____, _____
City State Month Day Year Applicant's Signature

Dated at _____, on _____, _____
City State Month Day Year Applicant B's Signature (if applying)

Premium Must Accompany Application

I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

(Signature of Licensed Producer)

(Signature of Licensed Producer)

PRODUCER STAMP

PRODUCER STAMP

ADDITIONAL INFORMATION: PART 4 - CON'T. HEALTH/MEDICAL QUESTIONS - Question #15

Applicant (please attach a separate sheet if needed)		Applicant B (please attach a separate sheet if needed)
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

SECTION FOR ADDITIONAL COMMENTS

Applicant (please attach a separate sheet if needed)	Applicant B (please attach a separate sheet if needed)

ASSURED LIFE ASSOCIATION

A Fraternal Benefit Society

Calculate Your Premium

Medicare Supplement

Medicare Supplement Plan _____

Before you begin: If you're not in your open enrollment or guarantee issue period, please go to page 2 to determine your eligibility for coverage.

Line	Steps	Example Rate displayed is used for calculation purposes only.	Applicant's Premium	Applicant B's Premium
#1	Premium Write in your Med supp plan's premium from the Outline of Coverage provided.	\$128.52		
#2	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		
#3	Fraternal Membership Dues There will be \$1.00 per month added to your renewal premiums as membership dues. To determine other payment schedules, multiply your monthly premium (+ \$1.00) 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 + \$1.00 = \$129.52 monthly payment \$388.56 quarterly payment \$777.12 semiannual payment \$1,554.24 annual payment		
#4	Enrollment/Certificate 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 premium amounts.	\$129.52 + \$25.00 = \$154.52 Example shows initial payment (monthly schedule).		

Complete and return with application

Height and Weight Chart

Eligibility

To determine whether you may purchase coverage, locate your height, then weight in the chart below. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time. If your weight is located in the Standard column, you may continue to step 1.

	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

ASSURED LIFE ASSOCIATION

Administrative Office

P.O. Box 2397

Omaha, Nebraska 68103-2397

www.denverwoodmen.com

Certificate forms MTA1, MTA2, MTA3, MTA4, MTA5, MTA6, MTA7, MTA8, MTA9, MTA10, MTA11 or state equivalent.

ASSURED LIFE ASSOCIATION

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Certificate Delivery

Mail certificates to:

- (a) Applicant Producer
- (b) Applicant B Producer

Producer(s) Information

Producer Name _____ Social Security No _____
Comm. % Share _____ Producer Phone No (____) _____ Commission Code _____
Producer E-mail Address _____ @ _____
Producer FAX Number _____

Producer Name _____ Social Security No _____
Comm. % Share _____ Producer Phone No (____) _____ Commission Code _____
Producer E-mail Address _____ @ _____
Producer FAX Number _____

Producer To Complete Only If Premium Is To Be Paid With A Business Check/Account

Initial Payment

- Is the applicant: Yes No
- (a) unemployed?
 - (b) employed, but not working for the business that is paying the premium?
 - (c) the business owner or spouse of the business owner?

If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

Renewal Payment

- Is the applicant: Yes No
- (a) unemployed?
 - (b) employed, but not working for the business that is paying the premium?
 - (c) the business owner or spouse of the business owner?

If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

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Initial Premiums Paid through Automated Clearing House (ACH)

Medicare supplement applications may have their initial premiums automatically deducted from their checking or savings account through the specific Electronic Funds Transfer (EFT) process identified as Automatic Clearing House (ACH). 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 ACH for initial premiums:

Step 1 - COMPLETE THE AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (ACH/BSP) FORM

Applicants wishing to pay electronically complete the appropriate Med supp *Authorization for Electronic Funds Transfer* form*:

T01_13 for Assured Life Association

To Pay:

- Only the **initial premium** via EFT, complete the top portion as well as the account information on the Med supp *Authorization for Electronic Funds Transfer* form
- Both the **initial and renewal premiums** via EFT, complete the entire form, including the account information

Step 2 - FAX THE FOLLOWING ITEMS TO THE DEDICATED LINE FOR ACH PAYMENTS AT 402-997-1910

1. ACH fax transmittal cover sheet on the back of this form, T00_133*
2. Med supp *Authorization for Electronic Funds Transfer* form, T01_13*
3. Med supp application and other required forms

Tips for Submitting Initial Premiums through ACH

- 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

*In the application package

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

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P.O. Box 2397
Omaha, NE 68103-2397

FAX Transmittal Cover Sheet For Application With Initial Payment By ACH

Fax Applications and New Business Documents ONLY to 1-402-997-1910
NOTE: Applications faxed to the wrong fax number could cause processing delays.

Producer Name	Producer Number or SSN
Phone Number	Producer FAX Number

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

COMMENTS: _____

If you have questions with regard to this process, please contact Sales Support at 877-815-4776.

This communication and any attachments transmitted with it are confidential and are solely for the use of the addressee. It may contain material that is legally privileged, proprietary or subject to copyright belonging to Assured Life Association and its affiliates, and it may be subject to protection under federal or state law. If you are not the intended recipient, you are notified that any use of this material is strictly prohibited. If you received this transmission in error, please contact the sender immediately by telephone, collect calls accepted, at the number shown above. We will arrange for you to return the original material to us via the U.S. Postal Service, and if requested, we will reimburse you for such expense.

INSTRUCTIONS FOR COMPLETION OF AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (ACH/BSP) FORM

Account Holder Name	Check Number																
<div style="border: 2px solid black; padding: 10px; margin: 10px auto; width: 80%;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">John Doe</td> <td style="width: 40%; text-align: right;">Check #1234</td> </tr> <tr> <td>Street Address</td> <td></td> </tr> <tr> <td>Town, City Zip code</td> <td style="text-align: right;">Date: _____</td> </tr> <tr> <td colspan="2">Pay to: _____</td> </tr> <tr> <td colspan="2" style="text-align: right;">_____ Dollars</td> </tr> <tr> <td colspan="2">Bank Name & Address</td> </tr> <tr> <td>Memo _____</td> <td>Signed By: _____</td> </tr> <tr> <td colspan="2" style="text-align: center;"> ⑆123456789⑆ 12345678 ⑆ 1234 ⑆ </td> </tr> </table> </div>		John Doe	Check #1234	Street Address		Town, City Zip code	Date: _____	Pay to: _____		_____ Dollars		Bank Name & Address		Memo _____	Signed By: _____	⑆123456789⑆ 12345678 ⑆ 1234 ⑆	
John Doe	Check #1234																
Street Address																	
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Memo _____	Signed By: _____																
⑆123456789⑆ 12345678 ⑆ 1234 ⑆																	
Bank Routing/ Transfer Number	Bank Account Number	Check Number (if shown at bottom, may be before or after the account #)	Do NOT include the check number as part of either the Routing or Account Number.														

The applicant may select one of three payment options indicated on the back side of this form. Instructions for each option are listed below. With each option, the form must be signed and dated.

Option A: Pay all premiums (1st month and monthly renewals) by Electronic Funds Transfer (EFT).

Automatic Clearing House (ACH) is used for initial payment and **Bank Service Plan (BSP)** is used for renewal payments. When choosing to pay both the initial and monthly renewals by EFT, the applicant must complete the form and submit it with the application. **DO NOT** submit a signed check for payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account numbers, name of financial institution) on the form.

Option B: Pay 1st month by paper check and monthly renewals by BSP

When choosing to pay the initial premium via paper check and the monthly renewals by BSP, the applicant must complete the form and submit it with the application. A signed check for the initial monthly premium must be submitted with the application.

Option C: Pay 1st month by ACH and pay renewals by direct bill (monthly direct billing is not offered)

When choosing to pay the initial premiums by ACH and renewal premiums by direct billing (quarterly, semiannually, or annually), the applicant must complete the form and submit it with the application. **DO NOT** submit a signed check for the initial premium payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account number, name of financial institution) on the form.

When choosing to pay initial premiums by ACH, money will be withdrawn on the date the application is processed. This may be different from the monthly withdraw date selected for renewal premiums.

Payments cannot be postponed until a later date.

Payment from a third party, including any foundation, cannot be accepted.

All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Please complete the Electronic Funds Transfer form accurately and in its entirety, making sure that all required information is correct and complete on your Electronic Funds Transfer form prior to submission. In addition, please make sure that the premium amount is filled in on the Electronic Funds Transfer form so we can initiate a timely and accurate withdrawal from your client's bank account.

An example of how to find correct Routing and Account Numbers on your clients' checks is included at the top of this form. Do not include the check number as part of either the Routing or Account Number. The applicant's bank name is normally included above the Memo line on the check.

ASSURED LIFE ASSOCIATION

A Fraternal Benefit Society

Conditional Receipt

Check or Money Order Application

All premiums must be made payable to the Assured Life Association.

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

Applicant

Received of _____

this _____ day of _____,

an application for Form _____ Certificate and/or Riders _____ and

Check or Money Order for _____ Dollars.

Should the Company decline to issue the insurance applied for, I hereby agree to return the above sum to the applicant.

Agent _____

Applicant B

Received of _____

this _____ day of _____,

an application for Form _____ Certificate and/or Riders _____ and

Check or Money Order for _____ Dollars.

Should the Company decline to issue the insurance applied for, I hereby agree to return the above sum to the applicant.

Agent _____

NOTICE TO APPLICANT: Eligibility for the health and accident insurance applied for is conditional upon all of the following:

(a) payment of the full, initial premium; (b) written application; (c) satisfying the Company's underwriting standards.

If you are not eligible, no insurance or temporary or interim insurance of any kind will be effective.

Complete Receipt in full and leave with applicant at time of application.

Assured Life Association - 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: ASSURED LIFE ASSOCIATION, DIRECTOR OF INDIVIDUAL UNDERWRITING, P.O. BOX 2397, OMAHA, NE 68103-2397.

Give this notice to the applicant.

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Authorization To Disclose Personal Information To Assured Life Association

Meanings of Terms

“Medical Persons and Entities” means: all physicians, 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.

“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.

“Psychotherapy Notes” means: 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.

“Specified Companies” means:

- The group of companies which presently includes Assured Life Association and additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me to Assured Life Association.

Purposes

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.

Potential for Rediscovery

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.

Failure to Sign

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting
Assured Life Association
P.O. Box 2397
Omaha, Nebraska 68103-2397

I realize that my right to revoke this authorization is limited to the extent that Assured Life Association has taken action in reliance on the authorization or the law allows Assured Life Association to contest the issuance of the certificate or a claim under the certificate.

Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Names and Signatures

Name(s) used for medical records (if different than the name(s) below): _____

Applicant	Applicant B
Printed Name of Proposed Applicant	Printed Name of Proposed Applicant
Signature of Proposed Applicant	Signature of Proposed Applicant
Date	Date

ASSURED LIFE ASSOCIATION

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

Save this notice! It may be important to you in the future.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a certificate to be issued by Assured Life Association. Your new certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the certificate.

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 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 certificate.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement certificate 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 certificate is being purchased for the following reason(s) (check one):

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

If you still wish to terminate your present policy or certificate 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 though your certificate 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 or certificate until you have received your new certificate and are sure that you want to keep it.

X _____
Signature of Agent, Broker or Other Representative

ASSURED LIFE ASSOCIATION, P.O. Box 2397, Omaha, Nebraska 68103-2397

Applicant	Applicant B
Signature	Signature
Date	Date

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Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement certificate 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 certificate is being purchased for the following reason(s) (check one):

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

If you still wish to terminate your present policy or certificate 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 though your certificate 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 or certificate until you have received your new certificate and are sure that you want to keep it.

X _____
Signature of Agent, Broker or Other Representative

ASSURED LIFE ASSOCIATION, P.O. Box 2397, Omaha, Nebraska 68103-2397

Applicant	Applicant B
Signature	Signature
Date	Date

ASSURED LIFE ASSOCIATION

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Medicare Select Certificate 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 certificate of equal or lesser benefits offered in my state by Assured Life Association;
 - (f) Assured Life Association's Quality Assurance Program; and
 - (g) Assured Life Association's Grievance Procedures.

I also understand the following:

Assured Life Association does not recommend the purchase of a Medicare Select certificate 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