MARQUETTE NATIONAL
LIFE INSURANCE COMPANY

Medicare Supplement Insurance

from Marquette National Life Insurance Company,
a member of the Universal American family of companies.

OHIO
MQ-MS-APPK-10-OH-N

MARQUETTE NATIONAL LIFE INSURANCE COMPANY
Home Office: Houston, Texas **Administrative Office:** P. O. Box 13547, Pensacola, Florida 32591-3547 **Phone:** (800) 934-8203

Fair Credit Reporting Act Pre-Notification Form

Thank you for considering Marquette National Life Insurance Company as your insurance carrier. Your application will be processed as quickly as possible. Public Law 91-508 requires that we advise you that an investigative consumer report may be made in connection with this application which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through personal interviews with friends, neighbors and associates. Upon written request a complete and accurate disclosure of the "nature and scope" of the report if one is made will be provided.

MIB, Inc. Disclosure Notice

Information regarding your insurability will be treated as confidential. Marquette National Life Insurance Company or its reinsurers may, however, make a brief report thereon to the 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Marquette National Life Insurance Company, or its reinsurers, may also release information from 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.

INITIAL PREMIUM RECEIPT

MAKE CHECK PAYABLE TO: MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Received from____ (Applicant) an application for a Policy with Marquette National Life Insurance Company, Pensacola, Florida and $_______________for the initial premium. In the event that the application is not accepted by the Company, the above amount will be refunded. No obligation is incurred by the Company unless said application is approved by the Company at its home office and a policy is issued.

________________ ____

Date Agent

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

Please return the Application Form, any Bank Draft Card or Credit Card Authorization and Replacement Form, along with your initial premium check to Marquette National Life Insurance Company. The Initial Premium Receipt and accompanying notices remain with you.

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Notice to Agent regarding completion of the Application Package

"Return to Company"
The pages that follow which are printed with "Return to Company" at the bottom are to be removed from the application package. Only those forms completed in the application process need be returned to the Company.

The forms included in this application package are:

- Medicare Supplement Underwriting Guide
- State approved Medicare Supplement Application
- HIPAA form
- Pre-authorized Check and Credit Card forms
- Replacement forms
- Other state specific forms
- Guaranteed Issue Application

"Leave with Applicant"
The remaining pages (outer shell) which are printed with "Leave with Applicant" at the bottom are to be left with the applicant.

MARQUETTE NATIONAL
LIFE INSURANCE COMPANY

Medicare Supplement Underwriting Guide

The underwriting guide is designed to assist our agents in selecting and properly classifying qualified applicants for Medicare Supplement coverage. It should not be interpreted as a guarantee of final underwriting action on a specific case, as on occasion additional information gathered as a result of the selection process may impact the final decision.

In addition to the information that is provided on the application as part of the selection process, each applicant will be checked in the MIB database, a Pharmaceutical database and may also be subject to a telephone interview. With this in mind, it is of critical importance that all questions be asked, that the answers be accurately recorded, and that all medications used be listed on the application.

Qualification Criteria

Other than Open Enrollment and Guaranteed Issue situations, to qualify for Medicare Supplement coverage each applicant:

- Must be able to answer **no** to the health questions 1 thru 7 on the application. *Any yes answer means that the applicant is not eligible for coverage and the application should not be submitted.*
- Must meet the height and weight requirements listed on the build chart that is included in this guide. *Applicants that do not meet the stated weight maximum will not be eligible for coverage.*
- Must not have taken within the past 24 months any of the medications listed as uninsurable.

Premium Rate Classes

Two premium rate classes are available for the applicants that satisfied the initial qualification criteria -**Standard and Preferred.** The underwriting criteria for each of the classes is as follows:

- **Standard….** a "**yes**" answer to the tobacco question and is taking only maintenance medications that are not included in the uninsurable list. Important to note any applicant who is taking **any oral medication for diabetes is only eligible for the standard premium rate class.**
- **Preferred…** a "**no**" answer to the tobacco question and is taking maintenance medications that are not on the uninsurable list and not taking any type of oral medication for diabetes.

Uninsurable Medications

The Medications that are being taken by a proposed insured are an important consideration in the underwriting process. The following lists of medications are used to treat significant health conditions/problems and are not insurable and the application should not be submitted.

The list below is not all inclusive as many of these medications have generic forms and new medications are introduced frequently. Questions, as always, should be directed to the Medicare Supplement underwriter.

A
Adriamycin
Akineton
Aldesleukin
Alkeran
Antabuse
Aricept
Atrane
Azathioprine
AZT

B
Baclofen
Bendopa
Bromocriptine
Bulsufan

C
Carbidopa
Clozapine
Clozaril
Cogentin
Compazine
Cytoxan

D
Dantrium
Diethylstilbesterol
Disipal
Donepezil
Dopar
Doxorubicin

E
Eldepryl
Emcyt
Ergoloid
Etoposide
Eulexin
Exelon

F
Femara
Floxuridine
Foscavir

G
Galantamine
Ganite

H
Hexalen
Hydergine
Hydrea
Hydroxyurea

I
Idalycin
Imuran
Insulin
Interferon

K
Kemadrin

L
Larodopa
Letrozole
Leukeran
Leukin
Levadopa
Lioresal
Lithane
Lithium
Lupron

M
Megace
Mellaril
Memantine
Methadone
Methotrexate
Mitoxantrone
Moban
Mutamycin

N
Namenda
Navane
Neosar
Niloric
Nitroglycerin/Nitra
Novatrone

O
Oncovin

P
Parlodel
Parsidol
Permax
Platino
Prednisone
(depends on reason and dosage)
Purinethol

R
Remicaide
Reminyl
Retrovir
Rilutek
Riluzole
Risperdal

S
Serentil
Sinemet.
for Parkinson's
Stelazine
Symmetrel
Synapton

T
Tacrine
Teslac
Thioplex
Thiotepa
Thorazine
Ticlid
Triptorelin

V
Velban
Viadur
Viodex

Z
Zanosar
Ziprasidone
Zoladex
Zyprexa

Height and Weight Chart

Height	***4'9***	***4'10***	***4'11***	***5'0***	***5'1***	***5'2***	***5'3***	***5'4***	***5'5***	***5'6***	***5'7***	***5'8***	***5'9***	***5'10***	***5'11***	***6'0***	***6'1***	***6'2***	***6'3***	***6'4***	***6'5***	***6'6***	***6'7***	***6'8***	***6'9***
Minimum Weight	87	89	90	92	94	96	98	100	102	104	108	112	116	120	122	124	126	128	130	135	140	145	150	155	160
Maximum Weight	180	185	195	205	215	225	235	245	255	260	270	275	280	285	290	300	310	320	325	335	340	345	350	355	360

Additional Underwriting Information

When to Submit an Application

Marquette National's Medicare Supplement plans can be written up to 6 months prior to the proposed effective date of coverage.

Effective Date of Coverage

The effective date of coverage will be the day the application is approved unless another date is requested.

Issue State

Marquette National's Medicare Supplement plans can only be written by properly licensed and appointed agents in the applicant's state of residence for plans approved in that state.

Replacements

Marquette National does not condone the replacement of existing Medigap or Med Advantage coverage unless it is in the best interest of the applicant. When this is the case, be sure to complete the enclosed state approved replacement form. The Company will generally decline to issue any policy that replaces an in force Medigap policy issued by any company owned or controlled by parent company Universal American Corp. If any such policy is issued, no commission will be paid thereon, and any commission paid in error will be subject to chargeback by the Company.

Personal History Interviews

A telephone interview may be conducted by the Company to verify vital information (on application questions) necessary to properly evaluate the risk. This information is strictly for underwriting purposes only. Please make sure your applicants are aware that someone may be contacting them for this interview and note the best times to call that would be the most convenient for your applicant. There is a space on the application to note this time. When possible, we will attempt to call at the requested time.

Open Enrollment

Open Enrollment is the first 6 months immediately following the applicant's enrollment in Medicare Part B for applicable ages 65 and older. An applicant applying for a Medigap insurance policy during an Open Enrollment is eligible for any available plan offered by the Company, without providing medical evidence of insurability.

Medigap Rights and Protections (Guaranteed Issue Rights)

In those situations where the applicant's original coverage is being terminated **involuntarily,** they have the right to buy MediGap coverage. In these situations the Guaranteed Issue application included in this app pack should be used in conjunction with the standard application, Parts I and II. In most cases the applicant must apply for a Medigap policy within 63 calendar days after the date coverage ends. When Guaranteed Issue is requested, a copy of this documentation is required before a policy will be provided on a Guaranteed Issue basis.

Pre-Existing Condition Limitations

Refer to Part V of the included application for state specific details.

Creditable Coverage

Refer to Part IV of the included application for state specific details.

Open Enrollment Rate, Guaranteed Issue Rate, Application Fee, and Spousal Discounts

This information can be found at the bottom of the Medicare Supplement premium rate sheet.

Underage Medicare for the Disabled

Where required by state law, Marquette National offers underage Medicare Supplement for the disabled. If available in your state, plan and rate information can be found on the appropriate state premium rate sheet. All states that offer underage Medicare for the disabled require a 6 month open enrollment at age 65.

Rates and Renewability

The policy is guaranteed renewable as long as timely premium payments are made. We can only raise the premium if we do so on all like policies in the state. A premium increase may be due to a new table of rates, increase in the insured's age or a change in Medicare's benefit structure that changes the nature of the risk the Company assumed.

Supplemental Life Insurance Offer

All non-open enrollment applicants who have not applied for supplemental life coverage on the Medicare Supplement application will receive with their policy an offer to purchase pre-determined amounts of life insurance without providing additional evidence of insurability. This offer is only available for a stated period of time.

MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Home Office: Houston, Texas • **Administrative Office:** P.O. Box 13547, Pensacola, Florida 32591-3547

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

PART I: APPLICANT INFORMATION

Proposed Insured	Spouse
Name:	Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone #: ( ) Best time to call ______ AM or PM	Phone #: ( ) Best time to call ______ AM or PM
Social Security #: - - DOB: / /	Social Security #: - - DOB: / /
Medicare #:	Medicare #:
Height: Weight: Sex: Age:	Height: Weight: Sex: Age:
Have you used tobacco within the last 12 months? YES ☐ NO ☐	Have you used tobacco within the last 12 months? YES ☐ NO ☐
Name & Address of family doctor:	Name & Address of family doctor:
Beneficiary:	Beneficiary:
Relationship:	Relationship:
Proposed Effective Date:	Proposed Effective Date:

PART II: COVERAGE APPLIED FOR

MEDICARE SUPPLEMENT PLAN		MEDICARE SELECT PLAN	
PROPOSED INSURED	SPOUSE	PROPOSED INSURED	SPOUSE
Plan ____ Premium Class ______	Plan ____ Premium Class ______	Plan ____ Premium Class ______	Plan ____ Premium Class ______

PART III: MEDICAL & GENERAL (A telephone interview with the applicant(s) may be conducted to verify application)

Basic Questions (Answer for both Insureds)

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.

To the best of your knowledge:	**Proposed Insured**	**Spouse**
1. Did you turn age 65 in the last 6 months?	☐Yes ☐No	☐Yes ☐No
a. Did you enroll in Medicare Part B in the last 6 months?.	☐Yes ☐No	☐Yes ☐No
b. If yes, what is the effective date? Insured ______________ Spouse ______________		
2. Are you covered for medical assistance through the state Medicaid program? . . . . **(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**,	☐Yes ☐No	☐Yes ☐No
a. Will Medicaid pay your premiums for this Medicare supplement policy?.	☐Yes ☐No	☐Yes ☐No
b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.	☐Yes ☐No	☐Yes ☐No

Part III questions continue on next page

PART III: MEDICAL & GENERAL (A telephone interview with the applicant(s) may be conducted to verify application)

Basic Questions (Answer for both Insureds) Continued from previous page

To the best of your knowledge:	Proposed Insured	Spouse
3. a. 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. Insured: START __/___/___ END __/___/___ Spouse: 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?........	☐Yes ☐No	☐Yes ☐No
c. Was this your first time in this type of Medicare plan?........	☐Yes ☐No	☐Yes ☐No
d. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐Yes ☐No	☐Yes ☐No
4. a. Do you have another Medicare supplement policy in force?........	☐Yes ☐No	☐Yes ☐No
b. If so, with what company? Insured: ______ Spouse: ______		
c. What plan do you have? Insured: ______ Spouse: ______		
d. If so, do you intend to replace your current Medicare supplement policy with this policy? ...	☐Yes ☐No	☐Yes ☐No
5. Have you had coverage under any other health insurance within the past 63 days?........ (For example, an employer, union, or individual plan)	☐Yes ☐No	☐Yes ☐No
a. If so, with what company? Insured: ______ Spouse: ______		
b. What kind of policy? Insured: ______ Spouse: ______		
c. What are your dates of coverage under the other policy? Insured: START ____/____/_____ END ____/____/_____ Spouse: START ____/____/_____ END ____/____/_____ (If you are still covered under the other policy, leave "END" blank.)		

Health Questions (Answer for both Insureds)

Do not answer questions 1-8 if you are applying for this coverage within 6 months of obtaining Medicare Part B, or under guaranteed issue status. **IF THE ANSWER TO ANY OF QUESTIONS 1-7 IS "YES" FOR EITHER APPLICANT, THEN THAT APPLICANT IS NOT ELIGIBLE FOR COVERAGE AND HIS OR HER APPLICATION SHOULD NOT BE SUBMITTED.**	Proposed Insured	Spouse
1. Is any person to be insured currently hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, received home health care in the past 90 days; or has any such care been medically advised?	☐Yes ☐No	☐Yes ☐No
2. Has any person to be insured been diagnosed, treated or been advised by a physician that they have Alzheimer's Disease, Senile Dementia, Organic Brain Disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Parkinson's Disease, Muscular Dystrophy or paralysis?	☐Yes ☐No	☐Yes ☐No
3. Has any person to be insured tested positive for exposure to the HIV infection or been diagnosed and advised by a physician that they have Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?.	☐Yes ☐No	☐Yes ☐No
4. Has any person to be insured been diagnosed with Diabetes requiring the use of Insulin, Kidney Disease requiring dialysis, received or is awaiting an organ transplant?	☐Yes ☐No	☐Yes ☐No

Health Questions continue on next page

HEALTH QUESTIONS (ANSWER FOR BOTH PROPOSED INSUREDS) Continued from previous page

	Proposed Insured	Spouse
5. Within the past two years has any person to be insured had, been treated for or been advised by a physician to have treatment for:		
a. Congestive Heart Failure, Heart Attack, Angina (chest pain), Coronary Artery Disease, Cardiomyopathy, Stroke (CVA), Transient Ischemic Attack (TIA), Heart Rhythm Disorders requiring pacemaker or defibrillator?	☐Yes ☐No	☐Yes ☐No
b. Heart or circulatory surgery of any type including Angioplasty, Bypass, Stent Placement or a Valve Replacement?	☐Yes ☐No	☐Yes ☐No
c. Cancer (except skin cancer), Melanoma, Hodgkin's Disease or Leukemia?	☐Yes ☐No	☐Yes ☐No
d. Mental or Nervous Disorder requiring Psychiatric care, Alcohol or Drug Abuse (prescription or non-prescription), Cirrhosis of the Liver or Hepatitis C?.	☐Yes ☐No	☐Yes ☐No
e. Disabling/Crippling Arthritis, Osteoporosis with compression fractures, Degenerative Bone Disease, Systemic Lupus, or any other Connective Tissue Disease?.	☐Yes ☐No	☐Yes ☐No
f. Emphysema, Chronic Obstructive Pulmonary or Lung Disease, or use of Oxygen?.	☐Yes ☐No	☐Yes ☐No
6. Has any person to be insured been hospitalized two or more times within the past 24 months?	☐Yes ☐No	☐Yes ☐No
7. Has any person to be insured been advised to have surgery, medical tests or treatment that has not been performed or have they had medical test(s) for which they have not received the results?	☐Yes ☐No	☐Yes ☐No
8. Has any person to be insured taken any prescription medications within the past 12 months? . . If yes provide details (attach a separate sheet if necessary):	☐Yes ☐No	☐Yes ☐No

Proposed Insured	Spouse	Medication	Dosage	List Condition & Reason for Medication	How long
☐	☐				
☐	☐				
☐	☐				
☐	☐				
☐	☐				
☐	☐				
☐	☐				
☐	☐				

PART IV - CREDITABLE COVERAGE DETERMINATION

Within the last 63 days, have you been or were you covered under creditable coverage*?

Proposed Insured: ☐ Yes ☐No Spouse: ☐Yes ☐No

If "yes", what type of coverage? Insured: ____________________ Spouse: ____________________

If "yes", with what company? Insured: ____________________ Policy No.: ____________________

Spouse: ____________________ Policy No.: ____________________

*"Creditable Coverage" means (a) a group health plan; (b) health insurance coverage; (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare); (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928; (e) Chapter 55 of Title 10 (CHAMPUS); (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under chapter 89 of Title 5 (Federal Employees Health Benefits Program); (i) a public health plan (as defined in federal regulation); or (j) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)). Creditable Coverage does not include hospital indemnity, specified disease or illness, accident or disability income plans.

RETURN TO COMPANY

PART V - INSURED CERTIFICATION

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 will be suspended 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, substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan.

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).

To the best of my knowledge and belief, all of the answers to the above questions are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company and the full first premium has been paid; (b) this policy has a pre-existing condition limitation. A pre-existing condition means a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage. No coverage will be provided for a pre-existing condition until 6 months after the policy has been issued. All other conditions are covered from the date the policy is issued; and (c) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that he realized that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

Authorization: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, The Medical Information Bureau, Pharmaceutical Database, other organization, institution or person, that has any records or knowledge of me, or my health, to give Marquette National Life Insurance Company or its reinsurer(s) any such information. A photographic copy of this authorization shall be as valid as the original. **Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or false claim containing a false or deceptive statement is guilty of insurance fraud.**

I acknowledge receiving: (a) "A Guide to Health Insurance for People With Medicare"; (b) Outline of Coverage; (c) Investigative Consumer Report Notice; and (d) Medical Information Bureau (MIB) Disclosure Notice.

Signed at ______________________________ ____________________ Date ____________ ________

(City) (State) (Month/ Day) (Year)

X ______________________________ X ______________________________

(Applicant's Signature) (Spouse's Signature if applying for coverage)

RETURN TO COMPANY

PART VI - AGENT CERTIFICATION

The undersigned Agent certifies that the Applicant(s) has read, or had read to him/her, the completed application and that the Applicant(s) realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. AGENT COMPLETES (attach separate sheet, if necessary.)

TO AGENT: List all Health Insurance Policies sold to the applicant(s) which are still in force.

COMPANY ______________________________ TYPE ______________

List all Health Insurance Policies sold to the applicant(s) within the past 5 years which are no longer in force.

COMPANY ______________________________ TYPE ______________

I certify: (1) I have accurately recorded the information supplied by the Applicant(s); and (2) I have given an outline of coverage for the policy applied for and a "A Guide to Health Insurance for People With Medicare" to the Applicant(s).

X ______________________ ☐☐☐☐☐☐ ☐☐☐☐☐☐ ____% ______________ ______________

Licensed Agent's Signature | Agent's Code | Off. Code | Print Agent's Name | Agent's State Identification

X ______________________ ☐☐☐☐☐☐ ☐☐☐☐☐☐ ____% ______________ ______________

Secondary Agent's Signature | Secondary Agent Code | Off. Code | Secondary Agent Print Name | Secondary Agent Identification

Send Policy to: ☐ Agent ☐ Insured

SUPPLEMENT TO APPLICATION MN-MSUP-APP (1/06) OH

PLEASE PRINT

Proposed Insured ______________________ (if applying for coverage)

Spouse ______________________ (if applying for coverage)

Beneficiary ______________________ Beneficiary ______________________

Relationship ______________________ Relationship ______________________

Automatic Premium Loan ☐ Yes ☐ No Automatic Premium Loan ☐ Yes ☐ No

If you are in open enrollment or eligible for guaranteed issue for a Medicare Supplement/Select policy and are applying for life insurance, you must answer questions 1 through 8 on this application.

Issue ages 65-79 Primary Insured - Face Amount ☐ $2,500 ☐ $5,000 ☐$7,500 ☐ $10,000 ☐ _______*

Spouse - Face Amount ☐ $2,500 ☐ $5,000 ☐$7,500 ☐ $10,000 ☐ _______*

* Amount must be between $2,500 and $10,000.

Is any insurance applied for intended to replace any life insurance or annuity currently in force? . . . .

PROPOSED INSURED ☐ Yes ☐No SPOUSE ☐ Yes ☐ No

If "Yes" complete and attach the appropriate replacement forms (if applicable).

Proposed Insured: ______________________ ______________
Company Policy Number

Spouse: ______________________ ______________
Company Policy Number

I hereby apply for life insurance as shown above based on my attached application. The answers are, to the best of my knowledge and belief, true. I agree any policy shall not be effective until it has actually been issued.

Date: ______________ Signature of Proposed Insured: X ______________________
(if applying for coverage)

Date: ______________ Signature of Spouse: X ______________________
(if applying for coverage)

PREMIUM MODE:

DIRECT	CREDIT CARD
☐ Annual	☐ Annual
☐ Semi Annual	☐ Semi Annual
☐ Quarterly	☐ Quarterly
☐ Monthly PAC	☐ Monthly

	PREMIUM EXCLUDING POLICY FEE		POLICY FEE		TOTAL PREMIUM COLLECTED	
	Insured	Spouse	Insured	Spouse	Insured	Spouse
Medicare Supplement	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____
Life Insurance	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____
TOTAL AMOUNT COLLECTED					$ _____	$ _____

RETURN TO COMPANY

MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Home Office: Houston, Texas **Administrative Office**: P. O. Box 13547, Pensacola, Florida 32591-3547 Phone: (800) 934-8203

HIPAA AUTHORIZATION ADDENDUM

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I authorize any health care provider, including any physician, practitioner, pharmacy, hospital or medically-related facility, and any insurance company, MIB, Inc., Pharmaceutical Database, employer, or, except in AZ and WI, any other organization, institution or person that has my records or knowledge of me or my dependent(s) to disclose to Marquette National Life Insurance Company (The Company) and its reinsurers, or its authorized representative, any and all such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, records of use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by The Company personnel to determine eligibility for life and/or health insurance and life and/or health insurance benefits. The Company may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. I further authorize The Company, and its reinsurers, to disclose information to MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. The information may be disclosed by The Company to MIB, Inc., who, upon request, may also disclose such information about you in its file to another member company with whom you apply for life or health insurance or to whom a claim for benefits may be submitted. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask The Company to correct, amend or delete any incorrect personal information. A copy of The Company's "Notice of Privacy Practices" is available upon request.

This authorization shall be valid for a period of two (2) years from the date signed, one (1) year in Kansas. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to The Company's Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke is also subject to the rights of The Company under any law granting The Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

Patient's Name: ____
First *Middle* *Last*

Other Names Used: ____

Date of Birth: ____________________ Social Security Number: ____________________

Signature of Applicant: X______________________________ Date: __________
(Signature of Parent or Legal Guardian required if child is under 18)

Signature of Spouse: X______________________________ Date: __________
(If applying for coverage)

Signature of Authorized Representative: X________________ Relationship: __________ Date: __________

Authorized Representative's Address: ____

Authorized Representative's Phone Number: ____

RETURN TO COMPANY

☐ American Exchange Life Insurance Company
☐ American Pioneer Life Insurance Company
☐ Constitution Life Insurance Company
☐ Marquette National Life Insurance Company
☐ The Pyramid Life Insurance Company
☐ American Progressive Life & Health Insurance Company of New York
☐ Pennsylvania Life Insurance Company
☐ Union Bankers Insurance Company

Hereinafter referred to as "the Insurance Company".

NAME OF INSURED (Please Print) ______________________________

☐ Check here when reporting a change and provide Policy Number: ______________________________

PRE-AUTHORIZATION FORM

To Honor Drafts or Electronic Debits

As a convenience to me, I hereby request and authorize you to pay and charge my bank checking or savings account drafts or electronic debits drawn by and payable to the order of the Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each draft or debit shall be the same as if it were a draft on you and signed personally by me. This authority is to 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 or debit. I further agree that if any such draft or debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

____
Date

____
Bank Account Number ☐ Checking ☐ Savings

____
Bank Name (Please Print)

____
Bank Routing Number

____
Street Address or P.O. Box

____
Depositor's Name as it appears on Bank records

____
City State Zip

____
Signature(s) of Depositor(s) as it appears on Bank records

☐ Withdraw on the premium due date of my policy
☐ Withdraw on the following date*: ______________

SUBMIT THIS FORM AND A VOIDED CHECK TO THE HOME OFFICE

*Requested draft dates must be no more than 15 days **after** the policy due date, not in the following month, and no later than the 28th of the month.

PRE-AUTHORIZATION FORM*

For Recurring Payment with Credit Card

I authorize the Insurance Company to keep my signature on file and to charge my ☐MASTERCARD ☐VISA CARD account, on an ongoing basis, for amounts I owe.

I understand that this authorization is valid from the date indicated below unless I cancel the authorization through written notice. I also agree to contact the Insurance Company if there are any changes to my credit card account information.

Cardholder Name ______________________________

Cardholder Billing Address______________________________

City ______________________________ State______________ Zip ______________

Account Number ______________________________ Expiration Date ______________

Cardholder Signature ______________________________ Date ______________

*Restricted to products offering a Credit Card premium payment option on the application.

RETURN TO COMPANY

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MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Home Office: Houston, Texas **Administrative Office:** P. O. Box 13547, Pensacola, Florida 32591-3547 **Phone:** (800) 934-8203

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 policy to be issued by Marquette National Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your 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. 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 INSURER, AGENT

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 policy 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 prescription drug coverage and I am enrolling in Part D.
_______ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.
_______ Other. (Please Specify) ____

____

1. 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 (or coverage) 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 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.

X ____
Signature of Agent, Broker or other Representative

____
PRINTED Name and Address of Issuer, Agent, or Broker

X ______________________ X ______________________
Applicant's Signature Signature of Spouse, if applying

____
Date

 RETURN TO COMPANY

MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Home Office: Houston, Texas **Administrative Office:** P. O. Box 13547, Pensacola, Florida 32591-3547 **Phone:** (800) 934-8203

DESCRIPTION OF BENEFITS
MEDICARE SUPPLEMENT SELECT POLICY

Description of Medicare Supplement Select Program. Medicare Select Policies include restricted network provisions. You must use Hospitals which participate in a network program to receive full Medicare Supplement benefits.

Reduced benefits are payable if you are treated outside the Participating Hospital network. This means you will be responsible for paying the initial Part A Deductible amount if you are admitted outside the Participating Hospital Network.

Payment for covered expenses will not be restricted if you are admitted for emergency care, are admitted outside the service area and require urgently needed services, or the services you require are not available at a participating hospital. We reserve the right to determine and verify the non-availability of such services.

Medicare Select Outline of Coverage. Refer to the attached Outline of Coverage for a summary of benefits and premium rates. Use the Outline of Coverage to compare coverage and premiums with other Medicare Supplement policies or certificates offered by us and other companies.

Participating Hospital Network. The attached list includes names, addresses and phone numbers of our Participating Providers. Our Participating Providers are available twenty-four (24) hours per day, seven (7) days per week.

Quality Assurance Program. All Hospitals within the network are approved for reimbursement of Medicare benefits. They must also comply with the criteria set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHCO).

Grievance Procedure. We have a customer service program which can provide information to you, handle your complaints and help satisfy your concerns. This grievance procedure is intended to provide an opportunity for you and us to achieve mutual agreement for the settlement of disputes that have not been settled through our customer service program or that you desire to have settled by means of a written grievance. The following procedures are aimed at achieving mutual agreement for the settlement of disputes.

MMS-S DOB Continued on Reverse Side

ACKNOWLEDGEMENT

I acknowledge receipt of the provisions, restrictions and limitations of the Medicare Supplement Select Program as outlined in this MEDICARE SUPPLEMENT SELECT POLICY DESCRIPTION OF BENEFITS.

X ______________________________ ______________________
Signature of Proposed Insured Date

X ______________________________ ______________________
Signature of Spouse Date

 RETURN TO COMPANY

MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Home Office: Houston, Texas • **Administrative Office:** P.O. Box 13547, Pensacola, Florida 32591-3547

MEDICARE SUPPLEMENT GUARANTEED ISSUE DETERMINATION APPLICATION

COMPLETE ONLY IF APPLYING FOR A MEDICARE SUPPLEMENT POLICY ON A GUARANTEED ISSUE BASIS

For any applicant to be considered eligible for a Medicare Supplement policy on a guaranteed issue basis, ***other than during an open enrollment period***, the following information and appropriate documentation must be provided in addition to completion of the application for Medicare Supplement insurance.

If you are issued a Medicare Supplement policy on a guaranteed issue basis we will waive any pre-existing condition limitation.

Prior Coverage - Employee Welfare Benefit Plan

Within the last 63 days, did your employee welfare benefit plan terminate or cease to provide all benefits supplementing Medicare?

Proposed Insured: [ ] Yes [ ] No Spouse: [ ] Yes [ ] No

If you answer "yes", you are eligible for Medicare Supplement Plans A, F or N on a guaranteed issue basis.

Prior Coverage – Enrolled in a Medicare Advantage (formerly Medicare+Choice) Plan or With a PACE Provider That Had Been Elected Upon First Becoming Enrolled for Benefits Under Medicare Part A

Within the last 63 days, did you terminate enrollment from a Medicare Advantage (formerly Medicare+Choice) plan or a Program of All-Inclusive Care for the Elderly (PACE), having enrolled in such plan upon first becoming enrolled for benefits under Medicare Part A, and subsequently disenrolled within 12 months of enrollment?

Proposed Insured: [ ] Yes [ ] No Spouse: [ ] Yes [ ] No

If you answer "yes", you are eligible for any Medicare Supplement policy offered by the company on a guaranteed issue basis.

Prior Coverage - First time Enrollment in Medicare Select Policy, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan, Medicare Advantage (formerly Medicare+Choice) Plan, or with a PACE Provider After Termination of Medicare Supplement Coverage

1. Within the last 12 months, did you terminate Medicare Supplement coverage to enroll for the first time in a Medicare Select Plan, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan, Medicare Advantage (formerly Medicare+Choice) Plan, or a Program of All-Inclusive Care for the Elderly (PACE)?

   Proposed Insured: [ ] Yes [ ] No Spouse: [ ] Yes [ ] No

   If "yes", with what Company? ______________________________ Policy No. ______________

2. Within the past 63 days, did you terminate enrollment in such plan?

   Proposed Insured: [ ] Yes [ ] No Spouse: [ ] Yes [ ] No

If you answer "yes" to questions 1. and 2., you are eligible for the same Medicare Supplement plan, on a guaranteed issue basis, that you had prior to the election of the coverage that most recently terminated. However, application must be made to the same insurer that provided the Medicare Supplement coverage. If that insurer does not have that plan available, then you are eligible for a Medicare Supplement Plan A, F or N from this company on a guaranteed issue basis.

Company: ______________________________ Policy Number: ______________

Prior Coverage - Medicare Select Policy, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan, Medicare Advantage (formerly Medicare+Choice) Plan, or You Are 65 Years of Age or Older and Enrolled With a PACE Provider

Within the last 63 days, did you discontinue enrollment in a Medicare Select policy, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan, Medicare Advantage (formerly Medicare+Choice) Plan, or you are 65 years of age or older and discontinued enrollment in a Program of All-Inclusive Care for the Elderly (PACE) because:

a. the plan's certification was terminated or the plan was discontinued in the area in which you live?
   Proposed Insured: [ ] Yes [ ] No Spouse: [ ] Yes [ ] No

b. you changed your place of residence or there was another change in circumstance (other than nonpayment of premium) which made you ineligible for the plan?
   Proposed Insured: [ ] Yes [ ] No Spouse: [ ] Yes [ ] No

c. you have satisfactorily demonstrated that the organization substantially violated a material provision of the plan with respect to your care?
   Proposed Insured: [ ] Yes [ ] No Spouse: [ ] Yes [ ] No

d. you have satisfactorily demonstrated that the organization, agent or other entity acting on the plan's behalf, materially misrepresented the plan's provision in the marketing of the plan to you?
   Proposed Insured: [ ] Yes [ ] No Spouse: [ ] Yes [ ] No

If you answer "yes" to any questions a.- d., you are eligible for Medicare Supplement Plans A, F or N on a guaranteed issue basis.

RETURN TO COMPANY

Prior Coverage - Medicare Supplement Policy

Within the last 63 days, did your Medicare Supplement policy terminate because:

a. the insurer went bankrupt, became insolvent, or involuntarily terminated the plan and there is no state law or regulation for continuation or conversion of such coverage?

Proposed Insured: [ ] Yes [ ] No Spouse: [ ] Yes [ ] No

b. you have satisfactorily demonstrated that the insurer substantially violated a material provision of the policy with respect to your care?

Proposed Insured: [ ] Yes [ ] No Spouse: [ ] Yes [ ] No

c. you have satisfactorily demonstrated that the insurer, agent or entity acting on the company's behalf materially misrepresented the policy's provisions in marketing the plan to you?

Proposed Insured: [ ] Yes [ ] No Spouse: [ ] Yes [ ] No

If you answer "yes" to any question you are eligible for Medicare Supplement Plans A, F or N on a guaranteed issue basis.

Prior Coverage – Medicare Supplement Policy with Outpatient Prescription Drug Benefits

Did you enroll in a Medicare Part D plan during the initial enrollment period (November 15, 2005 to May 15, 2006), and at the time were you enrolled under a Medicare supplement policy that covers outpatient prescription drugs?

Proposed Insured: [ ] Yes [ ] No Spouse: [ ] Yes [ ] No

Effective date of your coverage under Medicare Part D: Proposed Insured: ____________________ Spouse: ______________
(The guaranteed issue period ends 63 days after the effective date of your coverage under Medicare Part D.)

Did you subsequently terminate your Medicare supplement policy?

Proposed Insured: [ ] Yes [ ] No Spouse: [ ] Yes [ ] No

If you answer "yes" to both questions, you are eligible for Medicare Supplement Plans A, F or N on a guaranteed issue basis.

If you are eligible for a Medicare Supplement policy on a guaranteed issue basis, you must provide appropriate documentation of your termination of or disenrollment from coverage or Medicare Part D enrollment along with your application for the Medicare Supplement policy. Appropriate documentation includes written information that identifies the plan of coverage, the date of the termination of or disenrollment from coverage and the reason for termination.

To the best of my knowledge and belief, the information provided above is true and correct. I understand that this application will become part of my application for coverage, and thus part of the policy. The company may investigate my responses to the questions, and the documentation that I have provided.

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

Signed at: ______________________________________ Date: ______________________________
City State

Signature: ______________________________________ Signature: ______________________________
Proposed Insured Spouse, if applying for coverage

Signature: ______________________________________ Producer's Code: ______________________________
Licensed Producer

Print Producer's Name: ______________________________ Producer's State Ins. Lic #: ______________________

Date: ______________________________________

RETURN TO COMPANY

MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Home Office: Houston, Texas **Administrative Office:** P. O. Box 13547, Pensacola, Florida 32591-3547 **Phone:** (800) 934-8203

DESCRIPTION OF BENEFITS
MEDICARE SUPPLEMENT SELECT POLICY

Description of Medicare Supplement Select Program. Medicare Select Policies include restricted network provisions. You must use Hospitals which participate in a network program to receive full Medicare Supplement benefits.

Reduced benefits are payable if you are treated outside the Participating Hospital network. This means you will be responsible for paying the initial Part A Deductible amount if you are admitted outside the Participating Hospital Network.

Payment for covered expenses will not be restricted if you are admitted for emergency care, are admitted outside the service area and require urgently needed services, or the services you require are not available at a participating hospital. We reserve the right to determine and verify the non-availability of such services.

Medicare Select Outline of Coverage. Refer to the attached Outline of Coverage for a summary of benefits and premium rates. Use the Outline of Coverage to compare coverage and premiums with other Medicare Supplement policies or certificates offered by us and other companies.

Participating Hospital Network. The attached list includes names, addresses and phone numbers of our Participating Providers. Our Participating Providers are available twenty-four (24) hours per day, seven (7) days per week.

Quality Assurance Program. All Hospitals within the network are approved for reimbursement of Medicare benefits. They must also comply with the criteria set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHCO).

Grievance Procedure. We have a customer service program which can provide information to you, handle your complaints and help satisfy your concerns. This grievance procedure is intended to provide an opportunity for you and us to achieve mutual agreement for the settlement of disputes that have not been settled through our customer service program or that you desire to have settled by means of a written grievance. The following procedures are aimed at achieving mutual agreement for the settlement of disputes.

MMS-S DOB Continued on Reverse Side

ACKNOWLEDGEMENT

I acknowledge receipt of the provisions, restrictions and limitations of the Medicare Supplement Select Program as outlined in this MEDICARE SUPPLEMENT SELECT POLICY DESCRIPTION OF BENEFITS.

X ______________________________ ______________________

Signature of Proposed Insured Date

X ______________________________ ______________________

Signature of Spouse Date

LEAVE WITH APPLICANT

All grievances:

- Must be presented in written form to Marquette National Life Insurance Company, c/o Grievance Appeal Manager, 411 N. Baylen Street, Pensacola, Florida 32502.
- Must contain the words "THIS IS A GRIEVANCE" or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to the grievance procedure.
- Will be processed within 60 days after it is received by us. If a grievance is found to be valid, corrective action will be taken promptly. All concerned parties will be notified about the result of the grievance.
- Must be filed within 1 year from the date of the occurrence of the cause of the grievance.

If you are still not satisfied after your grievance is reviewed and settled, you have the right to appeal to the Department of Insurance in your state or you may request arbitration. Arbitration must be conducted in accordance with the provisions of the applicable state statute.

If we request a personal meeting with you, we will schedule this meeting at a location or in a manner which is convenient for you and does not necessitate excessive travel or undue hardship.

Conversion. If you decide not to participate in our Participating Provider Network, you may convert your Medicare Supplement Select policy to any Medicare Supplement policy offered by us which has comparable or lesser benefits and which does not contain a restricted network provision. You will not have to provide evidence of insurability if your current policy has been in force for more than 90 days.

Continuation. In the event state regulators determine that Medicare Supplement Select policies issued should be discontinued due to either the failure of the Medicare Select Program to be re-authorized or its substantial amendment, we shall continue your coverage for a period of one year from the date we are notified of such discontinuance. Following the one year period, your Medicare Supplement Select policy is converted to a Medicare Supplement policy offered by us which has comparable or lesser benefits and which does not contain a restricted network provision.

Purchase Of Other Medicare Supplement Policies or Certificates. You have the right to purchase any other Medicare Supplement Policy or Certificate offered for sale by us in your state.

LEAVE WITH APPLICANT

MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Home Office: Houston, Texas **Administrative Office:** P. O. Box 13547, Pensacola, Florida 32591-3547 **Phone:** (800) 934-8203

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

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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 INSURER, AGENT

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 policy 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 prescription drug coverage and I am enrolling in Part D.
_______ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.
_______ Other. (Please Specify) ____

____

1. 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 (or coverage) 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 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.

X____
Signature of Agent, Broker or other Representative

____
PRINTED Name and Address of Issuer, Agent, or Broker

X______________________ X______________________
Applicant's Signature Signature of Spouse, if applying

____
Date

LEAVE WITH APPLICANT

Administrative Office
Senior Health Service Center
P.O. Box 13547
Pensacola, FL 32591-3547

Policyholder Services & Claims:
1-800-934-8203

www.marquettenationallife.com

UNIVERSAL AMERICAN

A Healthy Collaboration℠

Universal American (NYSE: UAM), through our family of healthcare companies, offers benefit plans designed to promote collaboration among our members and their healthcare professionals. This Healthy Collaboration℠ improves the health and well-being of over two million people with Medicare every day.

Marquette National Life is a member of the Universal American family of companies. Marquette National Life offers a portfolio of products to America's seniors, including supplemental health insurance and life insurance.

www.UniversalAmerican.com