Assured Life Association
A Fraternal Benefit Society
P.O. Box 2397
Omaha, Nebraska 68103-2397

APPLICATION for
MEDICARE SUPPLEMENT INSURANCE

MISSOURI

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07/21/2021

ASSURED LIFE ASSOCIATION

A Legal Reserve Fraternal Benefit Society

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

BENEFIT PLANS A, F, G AND N

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	PLAN A	PLAN B	PLAN D	**PLAN G**	**G[1]**	PLAN K	PLAN L	PLAN M	**PLAN N**	PLAN C	**PLAN F**	**F[1]**
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓		50%	75%	✓	✓ copays apply[3]	✓	✓	
Blood (first three pints each year)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2021 [2]						$6,220[2]	$3,110[2]					

[1]Plans F and G also have a high deductible option which require first paying a plan deductible $2,370 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2]Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3]Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

MONTHLY NON-TOBACCO PREMIUMS*

ZIP CODES: 634-639, 644-648, 650-658

FEMALE					MALE			
Plan A MTA20	Plan F MTA24	Plan G MTA25	Plan N MTA31	Issue Age	Plan A MTA20	Plan F MTA24	Plan G MTA25	Plan N MTA31
188.49	321.33	211.78	190.70	**Thru 64**	216.75	369.35	243.43	219.21
188.49	253.08	192.06	158.84	**65**	216.75	291.06	220.86	182.66
188.49	253.08	192.06	158.84	**66**	216.75	291.06	220.86	182.66
188.49	253.08	192.06	158.84	**67**	216.75	291.06	220.86	182.66
189.78	254.82	193.39	159.92	**68**	218.25	293.05	222.37	183.91
198.60	266.66	202.37	167.34	**69**	228.38	306.67	232.72	192.45
204.73	274.93	208.63	172.53	**70**	235.44	316.17	239.92	198.40
214.60	288.15	218.67	180.83	**71**	246.78	331.38	251.47	207.97
223.40	300.01	227.64	188.25	**72**	256.92	344.99	261.80	216.52
232.01	311.52	236.41	195.49	**73**	266.79	358.26	271.86	224.83
239.69	321.86	244.24	201.98	**74**	275.65	370.13	280.88	232.27
246.87	331.48	251.54	208.03	**75**	283.90	381.22	289.29	239.24
253.64	340.59	258.44	213.74	**76**	291.69	391.67	297.22	245.78
260.63	349.98	265.59	219.61	**77**	299.72	402.48	305.42	252.59
267.79	359.57	272.86	225.64	**78**	307.94	413.52	313.78	259.50
275.18	369.51	280.40	231.87	**79**	316.43	424.93	322.44	266.65
282.72	379.62	288.07	238.23	**80**	325.11	436.57	331.30	273.98
288.36	387.22	293.83	243.01	**81**	331.62	445.30	337.91	279.44
294.14	394.95	299.72	247.86	**82**	338.25	454.19	344.68	285.03
300.01	402.86	305.72	252.81	**83**	345.03	463.28	351.57	290.74
306.00	410.92	311.83	257.88	**84**	351.92	472.56	358.61	296.55
312.14	419.13	318.06	263.04	**85**	358.96	482.02	365.78	302.48
318.39	427.52	324.42	268.29	**86**	366.14	491.63	373.08	308.52
324.74	436.08	330.90	273.64	**87**	373.46	501.49	380.57	314.70
331.24	444.79	337.53	279.12	**88**	380.92	511.52	388.17	320.99
337.87	453.68	344.28	284.72	**89**	388.54	521.74	395.93	327.42
344.62	462.77	351.17	290.43	**90**	396.32	532.17	403.85	333.98
351.52	472.03	358.20	296.22	**91**	404.25	542.81	411.93	340.64
358.55	481.46	365.36	302.14	**92**	412.33	553.68	420.15	347.48
365.70	491.08	372.66	308.18	**93**	420.56	564.75	428.57	354.40
373.02	500.89	380.12	314.35	**94**	428.98	576.06	437.13	361.49
380.49	510.92	387.72	320.63	**95**	437.56	587.55	445.88	368.73
388.11	521.15	395.49	327.05	**96**	446.32	599.32	454.78	376.09
395.87	531.57	403.38	333.59	**97**	455.25	611.30	463.89	383.62
403.78	542.19	411.45	340.26	**98**	464.35	623.53	473.18	391.29
411.85	553.05	419.68	347.07	**99+**	473.63	636.01	482.63	399.12

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY TOBACCO PREMIUMS*

ZIP CODES: 634-639, 644-648, 650-658

FEMALE					MALE			
Plan A MTA20	Plan F MTA24	Plan G MTA25	Plan N MTA31	Issue Age	Plan A MTA20	Plan F MTA24	Plan G MTA25	Plan N MTA31
216.65	369.35	243.43	219.19	**Thru 64**	249.14	424.54	279.80	251.96
216.65	290.90	220.76	182.57	**65**	249.14	334.55	253.86	209.95
216.65	290.90	220.76	182.57	**66**	249.14	334.55	253.86	209.95
216.65	290.90	220.76	182.57	**67**	249.14	334.55	253.86	209.95
218.14	292.90	222.29	183.82	**68**	250.86	336.84	255.60	211.39
228.28	306.50	232.61	192.35	**69**	262.50	352.49	267.49	221.21
235.32	316.01	239.80	198.31	**70**	270.62	363.41	275.77	228.05
246.67	331.21	251.34	207.85	**71**	283.66	380.90	289.04	239.04
256.78	344.84	261.66	216.38	**72**	295.31	396.54	300.92	248.87
266.68	358.07	271.73	224.70	**73**	306.66	411.79	312.48	258.42
275.51	369.95	280.74	232.16	**74**	316.84	425.44	322.85	266.98
283.76	381.01	289.13	239.12	**75**	326.32	438.18	332.52	274.99
291.54	391.48	297.06	245.68	**76**	335.28	450.20	341.63	282.50
299.57	402.28	305.28	252.43	**77**	344.51	462.62	351.06	290.33
307.80	413.30	313.63	259.36	**78**	353.95	475.31	360.67	298.28
316.30	424.72	322.30	266.52	**79**	363.71	488.42	370.62	306.49
324.96	436.34	331.12	273.83	**80**	373.69	501.80	380.80	314.92
331.45	445.08	337.74	279.32	**81**	381.17	511.84	388.40	321.20
338.09	453.97	344.51	284.90	**82**	388.79	522.06	396.18	327.62
344.84	463.06	351.40	290.59	**83**	396.58	532.51	404.10	334.18
351.72	472.32	358.43	296.41	**84**	404.51	543.17	412.20	340.86
358.78	481.76	365.59	302.34	**85**	412.60	554.05	420.44	347.68
365.96	491.40	372.90	308.38	**86**	420.85	565.09	428.83	354.62
373.26	501.24	380.35	314.53	**87**	429.26	576.42	437.44	361.72
380.74	511.25	387.97	320.83	**88**	437.84	587.95	446.17	368.95
388.36	521.47	395.72	327.26	**89**	446.60	599.70	455.09	376.34
396.11	531.92	403.64	333.83	**90**	455.54	611.69	464.20	383.89
404.04	542.56	411.72	340.48	**91**	464.65	623.92	473.48	391.54
412.13	553.40	419.95	347.29	**92**	473.94	636.41	482.93	399.40
420.35	564.46	428.34	354.23	**93**	483.40	649.14	492.61	407.36
428.76	575.74	436.92	361.32	**94**	493.08	662.14	502.45	415.51
437.34	587.26	445.66	368.54	**95**	502.94	675.35	512.50	423.83
446.10	599.02	454.58	375.92	**96**	513.01	688.87	522.74	432.29
455.02	611.00	463.66	383.44	**97**	523.27	702.64	533.21	440.94
464.12	623.21	472.93	391.10	**98**	533.74	716.70	543.88	449.76
473.39	635.69	482.39	398.93	**99+**	544.40	731.04	554.75	458.76

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY NON-TOBACCO PREMIUMS*

ZIP CODES: 630-631, 633, 640 - 641

FEMALE					MALE			
Plan A MTA20	Plan F MTA24	Plan G MTA25	Plan N MTA31	Issue Age	Plan A MTA20	Plan F MTA24	Plan G MTA25	Plan N MTA31
218.64	372.75	245.67	221.21	**Thru 64**	251.43	428.45	282.37	254.28
218.64	293.58	222.79	184.25	**65**	251.43	337.63	256.20	211.88
218.64	293.58	222.79	184.25	**66**	251.43	337.63	256.20	211.88
218.64	293.58	222.79	184.25	**67**	251.43	337.63	256.20	211.88
220.15	295.60	224.34	185.51	**68**	253.17	339.94	257.95	213.34
230.38	309.32	234.75	194.12	**69**	264.92	355.73	269.95	223.25
237.49	318.92	242.01	200.14	**70**	273.11	366.75	278.31	230.15
248.94	334.26	253.65	209.76	**71**	286.27	384.40	291.70	241.24
259.14	348.01	264.07	218.37	**72**	298.03	400.19	303.69	251.16
269.13	361.36	274.23	226.77	**73**	309.48	415.58	315.36	260.80
278.05	373.35	283.32	234.30	**74**	319.76	429.35	325.82	269.44
286.37	384.52	291.79	241.32	**75**	329.32	442.21	335.58	277.52
294.22	395.08	299.79	247.94	**76**	338.37	454.34	344.77	285.10
302.33	405.98	308.09	254.75	**77**	347.68	466.88	354.29	293.00
310.63	417.10	316.52	261.75	**78**	357.21	479.68	363.99	301.02
319.21	428.63	325.27	268.97	**79**	367.06	492.91	374.03	309.31
327.95	440.35	334.17	276.35	**80**	377.13	506.42	384.30	317.82
334.50	449.17	340.85	281.89	**81**	384.68	516.55	391.97	324.16
341.20	458.15	347.68	287.52	**82**	392.37	526.86	399.83	330.63
348.01	467.32	354.63	293.26	**83**	400.23	537.41	407.82	337.26
354.96	476.67	361.73	299.14	**84**	408.23	548.17	415.99	344.00
362.08	486.19	368.95	305.12	**85**	416.40	559.15	424.31	350.88
369.33	495.92	376.33	311.22	**86**	424.72	570.29	432.78	357.88
376.69	505.85	383.85	317.42	**87**	433.21	581.72	441.46	365.05
384.24	515.95	391.54	323.78	**88**	441.87	593.36	450.28	372.34
391.93	526.27	399.36	330.27	**89**	450.71	605.22	459.28	379.80
399.75	536.81	407.35	336.90	**90**	459.73	617.32	468.47	387.42
407.76	547.55	415.51	343.61	**91**	468.93	629.66	477.84	395.14
415.92	558.49	423.81	350.49	**92**	478.30	642.27	487.37	403.08
424.22	569.65	432.28	357.49	**93**	487.85	655.11	497.14	411.11
432.71	581.04	440.94	364.64	**94**	497.62	668.23	507.07	419.33
441.36	592.66	449.76	371.93	**95**	507.57	681.56	517.22	427.73
450.20	604.53	458.76	379.38	**96**	517.73	695.21	527.55	436.27
459.21	616.62	467.93	386.97	**97**	528.08	709.10	538.12	445.00
468.39	628.94	477.28	394.70	**98**	538.65	723.29	548.88	453.90
477.75	641.54	486.83	402.60	**99+**	549.41	737.77	559.85	462.98

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY TOBACCO PREMIUMS*

ZIP CODES: 630-631, 633, 640 - 641

FEMALE					MALE			
Plan A MTA20	Plan F MTA24	Plan G MTA25	Plan N MTA31	Issue Age	Plan A MTA20	Plan F MTA24	Plan G MTA25	Plan N MTA31
251.31	428.45	282.38	254.26	**Thru 64**	289.00	492.47	324.57	292.27
251.31	337.44	256.08	211.78	**65**	289.00	388.08	294.48	243.54
251.31	337.44	256.08	211.78	**66**	289.00	388.08	294.48	243.54
251.31	337.44	256.08	211.78	**67**	289.00	388.08	294.48	243.54
253.04	339.76	257.86	213.23	**68**	291.00	390.73	296.50	245.21
264.81	355.54	269.83	223.13	**69**	304.50	408.89	310.29	256.60
272.97	366.57	278.17	230.04	**70**	313.92	421.56	319.89	264.54
286.14	384.20	291.55	241.11	**71**	329.05	441.84	335.29	277.29
297.87	400.01	303.53	251.00	**72**	342.56	459.99	349.07	288.69
309.35	415.36	315.21	260.65	**73**	355.73	477.68	362.48	299.77
319.59	429.14	325.66	269.31	**74**	367.53	493.51	374.51	309.70
329.16	441.97	335.39	277.38	**75**	378.53	508.29	385.72	318.99
338.19	454.12	344.59	284.99	**76**	388.93	522.23	396.29	327.70
347.50	466.65	354.13	292.82	**77**	399.63	536.64	407.23	336.78
357.05	479.43	363.81	300.86	**78**	410.58	551.36	418.38	346.01
366.91	492.68	373.87	309.16	**79**	421.90	566.57	429.92	355.53
376.95	506.15	384.10	317.64	**80**	433.48	582.09	441.73	365.31
384.48	516.29	391.78	324.01	**81**	442.16	593.73	450.54	372.59
392.18	526.61	399.63	330.48	**82**	451.00	605.59	459.57	380.04
400.01	537.15	407.62	337.08	**83**	460.03	617.71	468.76	387.65
408.00	547.89	415.78	343.84	**84**	469.23	630.08	478.15	395.40
416.19	558.84	424.08	350.71	**85**	478.62	642.70	487.71	403.31
424.51	570.02	432.56	357.72	**86**	488.19	655.50	497.44	411.36
432.98	581.44	441.21	364.86	**87**	497.94	668.65	507.43	419.60
441.66	593.05	450.05	372.16	**88**	507.89	682.02	517.56	427.98
450.50	604.91	459.04	379.62	**89**	518.06	695.65	527.90	436.55
459.49	617.03	468.22	387.24	**90**	528.43	709.56	538.47	445.31
468.69	629.37	477.60	394.96	**91**	538.99	723.75	549.24	454.19
478.07	641.94	487.14	402.86	**92**	549.77	738.24	560.20	463.30
487.61	654.77	496.87	410.91	**93**	560.74	753.00	571.43	472.54
497.36	667.86	506.83	419.13	**94**	571.97	768.08	582.84	481.99
507.31	681.22	516.97	427.51	**95**	583.41	783.41	594.50	491.64
517.48	694.86	527.31	436.07	**96**	595.09	799.09	606.38	501.46
527.82	708.76	537.85	444.79	**97**	606.99	815.06	618.52	511.49
538.38	722.92	548.60	453.68	**98**	619.14	831.37	630.90	521.72
549.13	737.40	559.57	462.76	**99+**	631.50	848.01	643.51	532.16

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

Disclosures

Use this outline to compare benefits and premiums among certificates or policies.

Premium Information

The premium for your certificate may change. A premium change can only occur on certificate renewal date. However, we cannot make such a change unless we make the same change to all certificates using this form issued in the same state to persons of the same classification.

There will be a one-time enrollment fee of $25.00 added to the first premium.

Premiums do not include dues.

Household Premium Discount

You are eligible for a household premium discount if you reside with your spouse (including civil union/domestic partner). The discounted premium will be priced 7% lower than the rates illustrated.

Read Your Certificate Very Carefully

This is only an outline describing your certificate's most important features. The certificate is your insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and your insurance company.

Right to Return Certificate

If you find that you are not satisfied with your certificate, you may return it to Assured Life Association at our administrative office, 3316 Farnam Street, Omaha, NE 68175. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all of your payments.

Policy Replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new certificate and are sure you want to keep it.

Notice

The certificate may not fully cover all of your medical costs. Neither Assured Life Association nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

Complete Answers Are Very Important

When you fill out the application for the new certificate, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your certificate and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Exclusions

Exclusions apply to your coverage. Please be sure to review the exclusions in your certificate. This certificate does not cover Part A benefits for benefit periods that begin while this certificate is not in force, and other exclusions apply.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,484	$0	$1,484 (Part A deductible)
61st through 90th day	All but $371 a day	$371 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $185.50 a day	$0	Up to $185.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A AND B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT			
First $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

Medicare first eligible before 2020 only

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A deductible)	$0
61st through 90th day	All but $371 a day	$371 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR – Medicare first eligible before 2020 only

*Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $203 of Medicare-approved amounts*	$0	$203 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0
Next $203 of Medicare-approved amounts*	$0	$203 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A AND B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT First $203 of Medicare-approved amounts*	$0	$203 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum benefit

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A deductible)	$0
61st through 90th day	All but $371 a day	$371 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT			
First $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum benefit

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A deductible)	$0
61st through 90th day	All but $371 a day	$371 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT First $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum benefit

Missouri — Producer Information – Please Complete

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

Preferred Method of Communication (Select one)

☐ Phone ☐ Fax ☐ Email Contact info: _____

Note: Producers must be under the same commission code to share or split commissions. Please update your contact information at http://www.mutualofomaha.com/.

Application Submission Checklist – Assured Life Association Medicare Supplement Coverage

☐ **Provide Applicant with the Guide to Health Insurance for People with Medicare**

☐ **Provide Applicant with the Outline of Coverage**
- Calculate the premium based on age at application date
- Tobacco rates do not apply during open enrollment or guaranteed issue situations

☐ **Complete the Calculate Your Premium form to determine rate**

☐ **Application (complete in full)**

Sections A & B: Plan and Applicant Information
- Select plan
- Enter Requested Effective Date
- Indicate where the policy is to be mailed

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

Section D: Household Premium Discount Information
- Indicate if eligible for a Household Premium Discount

Section E: Previous or Existing Coverage Information
- Please complete ALL questions in full

For Sections F and G – Refer to the Open Enrollment/Guaranteed Issue worksheet to help identify eligibility.

Section F: Please answer all of the following questions
- If either Applicant A or B answered "YES" to question 6 OR BOTH questions 7 and 8 in Section F, they can skip to Section I

Sections G & H: Health/Medication Information
- Do NOT answer if applicant is in an open enrollment or guaranteed issue period

Section I: Agreement and Authorization
- Make sure applicant(s) sign and date the application

Section K: To be Completed by Producer
- Make sure producer(s) sign and date the application

☐ **Complete the Method of Payment form and return with the completed application**
- Use premium determined by the **Calculate Your Premium form**
- The full modal premium is collected at the time of application

☐ **Complete Replacement Notice and leave a copy with the applicant (if applicable)**

☐ **Provide Applicant with Premium Receipt signed by agent (if applicable)**

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

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Open Enrollment and Guaranteed Issue Worksheet

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

ELIGIBILITY FOR OPEN ENROLLMENT

Applicant is:

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

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

ELIGIBILITY FOR GUARANTEED ISSUE

Evidence of eligibility is required for the following situations.

Applicant:

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

If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.

If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K or L that is sold in the applicant's state by any insurance company.

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

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

If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.

If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K or L that is sold in the applicant's state by any insurance company.

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

Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available:

- *If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.*
- *If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K or L that is sold in the applicant's state by any insurance company.*

Applicant was enrolled in a Medicaid plan or state-specific variation of a Medicaid plan, and:

- the applicant's state has Guaranteed Issue or Open Enrollment Rights for the loss of Medicaid or state-specific variation of a Medicaid plan

Reference the Underwriting Guidelines for states that have Guarantee Issue or Open Enrollment Rights for loss of Medicaid or state-specific variation of a Medicaid plan.

Acceptable Evidence of Eligibility (Can vary by situation, refer to Underwriting Guide):

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

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Assured Life Association

A Fraternal Benefit Society

Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan

Applicant A _____

Applicant B _____

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

	Steps	**Example** Rate displayed is used for calculation purposes only.	**Applicant A**	**Applicant B**
#1	**Age** Write in your age at the time of signing the application. **ZIP Code** Indicate your ZIP Code used to determine your rate.	65 51502		
#2	**Premium** Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.	$128.52		
#3	**Household Premium Discount** Please refer to the application for state specific household discount rules. **If rules apply,** multiply the amount from Step #2 by .93. **If rules do not apply,** enter the amount from Step #2.	$128.52 x .93 = $119.52 In this example, the person qualifies for the household premium discount.		
#4	**Fraternal Membership Dues** There will be $1.00 per month added to your initial and renewal premiums as membership dues.	$119.52 + $1.00 = $120.52 monthly payment		
#5	**Payment Options** Your monthly payment is the amount from Step #4 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)	$120.52 monthly payment $361.56 quarterly payment $723.12 semiannual payment $1,446.24 annual payment		
#6	**Enrollment/Policy Fee** There is a one-time application fee of $25.00. **This will be collected with your initial payment and will NOT affect your renewal premiums amount.**	$120.52 + $25.00 = $145.52 Example shows initial payment (monthly schedule).		

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Height and Weight Chart

Eligibility

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

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

Medicare supplement insurance is underwritten by
Assured Life Association
Administrative Office
P.O. Box 2397
Omaha, Nebraska 68103-2397

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Agent Writing # _____ FAV Key _____

Assured Life Association

A Fraternal Benefit Society

Application For Medicare Supplement Coverage

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

A. Plan Information (to be completed by Producer)

Applicant A	Applicant B
Plan (select one): ☐ Plan A ☐ Plan G ☐ Plan N **OR** If your Medicare Part A eligibility date is before 01/01/2020, this **additional** plan is an available option: ☐ Plan F	**Plan (select one):** ☐ Plan A ☐ Plan G ☐ Plan N **OR** If your Medicare Part A eligibility date is before 01/01/2020, this **additional** plan is an available option: ☐ Plan F
Requested Effective Date __ / __ / ____	**Requested Effective Date** __ / __ / ____
Deliver Certificate to Applicant A ☐ Producer ☐	**Deliver Certificate to** Applicant B ☐ Producer ☐

B. Applicant Information

Applicant A	Applicant B
Name (First/Middle Initial/Last)	Name (First/Middle Initial/Last)
Residence Address	Residence Address (if different from Applicant A'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 ___ – ___ – ____ (area code)	Home Phone ___ – ___ – ____ (area code)
E-mail Address	E-mail Address
Current Age _____ Date of Birth __ / __ / ____ mo day yr	Current Age _____ Date of Birth __ / __ / ____ mo day yr
☐ Male ☐ Female	☐ Male ☐ Female
Social Security # ___ – __ – ____	Social Security # ___ – __ – ____
Height Ft ___ In ___ Weight Lbs ___	Height Ft ___ In ___ Weight Lbs ___

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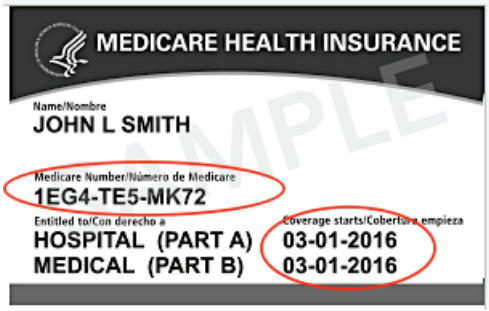
B. Applicant Information (continued)

Applicant A	Applicant B
Have you used tobacco in any form in the past 12 months? ..... ☐ Y ☐ N	Have you used tobacco in any form in the past 12 months? ..... ☐ Y ☐ N

C. Medicare Information

Please reference your Medicare card to complete this section.



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

D. Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.	**Applicant A**	**Applicant B**
1. Do you currently reside with your spouse or domestic partner?	☐ Y ☐ N	☐ Y ☐ N

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E. Previous or Existing Coverage Information

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

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
2. Are you covered for medical assistance through the state Medicaid program?..... (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.)	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Will Medicaid pay your premiums for this Medicare supplement certificate?.....	☐ Y ☐ N	☐ Y ☐ N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	☐ Y ☐ N	☐ Y ☐ N

Please answer questions regarding another Medicare supplement or Select plan:

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

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

Applicant B ___/___/_____

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

Applicant A	Applicant B
Name of Company	Name of Company
Plan	Plan
Effective Date	Effective Date

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

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

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

END ___/___/_____

Applicant B START ___/___/_____

END ___/___/_____

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

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

Applicant B ___/___/_____

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

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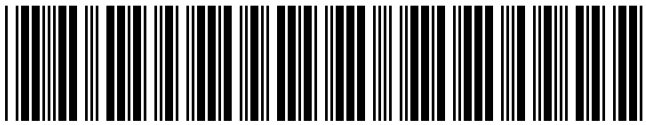
	Check box(s) below if applicable	
	Applicant A	Applicant B
(g) Please indicate reason for termination/disenrollment:		
■ Your Medicare Advantage plan is leaving the Medicare program.....	☐	☐
■ Your Medicare Advantage organization stopped offering Medicare Advantage plans.....	☐	☐
■ Your Medicare Advantage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

Please answer questions regarding other health insurance:

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

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

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



Applicant B START ___/___/_____
END ___/___/_____

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

(c) Have you disenrolled from your current coverage voluntarily?.....	☐ Y ☐ N	☐ Y ☐ N

(d) Please state the reason for your disenrollment:

_____
Applicant A

_____
Applicant B

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

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

F. Please answer all of the following questions:

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

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

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IF EITHER YOU OR APPLICANT B ANSWERED "YES" TO QUESTIONS 6, 7 OR 8 IN SECTION F, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS G & H AND GO TO SECTION I.

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

(Please see the enclosed material for explanation of the open enrollment and guaranteed issue periods.)

G. Health Information

For all plans, answer questions 9-19.

(If "YES" is answered to any of the following questions 9-18, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
9. Are you currently confined to a wheelchair or any motorized mobility device?	☐ Y ☐ N	☐ Y ☐ N
10. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?	☐ Y ☐ N	☐ Y ☐ N
11. Are you currently receiving any occupational, speech or physical therapy?	☐ Y ☐ N	☐ Y ☐ N
12. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed?	☐ Y ☐ N	☐ Y ☐ N
13. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	☐ Y ☐ N	☐ Y ☐ N
B. Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	☐ Y ☐ N	☐ Y ☐ N
C. Alzheimer's disease, dementia or any other cognitive disorder?	☐ Y ☐ N	☐ Y ☐ N
D. Parkinson's disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease)?	☐ Y ☐ N	☐ Y ☐ N
E. Systemic lupus, scleroderma or myasthenia gravis?	☐ Y ☐ N	☐ Y ☐ N
F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Y ☐ N	☐ Y ☐ N
G. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	☐ Y ☐ N	☐ Y ☐ N
H. Chronic hepatitis or cirrhosis?	☐ Y ☐ N	☐ Y ☐ N
I. Osteoporosis with fractures?	☐ Y ☐ N	☐ Y ☐ N
14. Do you have diabetes in addition to any of the following: retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, any heart disorder (including hypertension/high blood pressure), stroke, transient ischemic attack (TIA) or kidney disease?	☐ Y ☐ N	☐ Y ☐ N
15. Do you have an implanted cardiac defibrillator?	☐ Y ☐ N	☐ Y ☐ N
16. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	☐ Y ☐ N	☐ Y ☐ N
B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?	☐ Y ☐ N	☐ Y ☐ N
C. Alcoholism or drug abuse?	☐ Y ☐ N	☐ Y ☐ N
D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	☐ Y ☐ N	☐ Y ☐ N
E. Internal cancer, lymphoma or melanoma?	☐ Y ☐ N	☐ Y ☐ N
F. A stroke or transient ischemic attack (TIA)?	☐ Y ☐ N	☐ Y ☐ N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?	☐ Y ☐ N	☐ Y ☐ N
17. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts?	☐ Y ☐ N	☐ Y ☐ N
18. Have you been hospital confined three or more times in the past two years for a same or similar condition?	☐ Y ☐ N	☐ Y ☐ N
19. Have you taken any over-the-counter or prescription drugs in the past 24 months? **(If YES, please complete the Medication Information sheet on the next page)**	☐ Y ☐ N	☐ Y ☐ N

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H. Medication Information

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

Applicant A

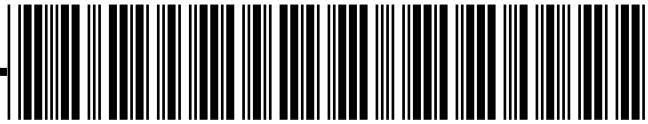
Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y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

Applicant B

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

T01-2013-23

I. Agreement and Authorization



IMPORTANT STATEMENTS

- 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 reinstituted 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 reinstituted 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 reinstituted 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 reinstituted 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).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO ASSURED LIFE ASSOCIATION

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Assured Life Association and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Assured Life Association. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, Assured Life Association, P.O. Box 2397, Omaha, NE 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.
- "Personal Information" means all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate certificate and a completed and signed application will become part of each applicant's certificate.

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

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

✍ Dated at _____, on ___/___/_____ _____
City State Month Day Year Applicant A's Signature

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

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J. To be Completed by Producer

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

Applicant A
Applicant B

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

Applicant A
Applicant B

I/We certify as follows:

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

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

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

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

_____

I acknowledge that if the applicant(s) is replacing coverage, I/We have provided a copy of the replacement notice.

✍ _____
Signature of Licensed Producer Date

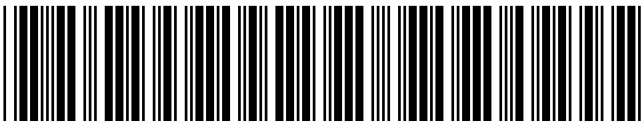
✍ _____
Signature of Licensed Producer Date

_____
Printed Name

_____
Printed Name

|_|_|_|_|_|_|_|_|
Agent Writing Number

|_|_|_|_|_|_|_|_|
Agent Writing Number



T01-2013-23

Producer Comments

List any additional comments or information below. Please return this form with the submitted application. If there are no comments you do not need to return this form.

Applicant A Name: _____ **Applicant B Name:** _____

_____
Producer Name (please print)

Agent Writing Number

31210

METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN PAGES 1 & 2

Fraternal Membership Dues

Assured Life Association is a fraternal benefit society that exists solely for the well being of its members and their beneficiaries. You and all other certificate holders ARE the company.

One dollar per month will be added to your premium for membership dues, and you become part of the growing fraternity that is Assured Life Association. Your dues dollars help to make a difference in your community. You are contributing towards scholarships that your children or grandchildren may apply for. A portion of the dues are also used to contribute to charitable organizations in the communities in which our membership lives. You may even find yourself getting together with other members in your area on a social and volunteer basis. The dues help support all of these programs plus other benefits and programs.

Assured Life Association has a host of other benefits, discounts, and special offers for you to take advantage of, all for $1.00 per month. Welcome to our society of fraternalists!

Part I . Select Premium Payment Option

	Applicant A	Applicant B
Initial Premium Payment (Select option #1 or #2)		
✍ **Initial premium amount** (based on age at application date).....	$ ____.__	$ ____.__
1. Paper Check (submit signed check with application)..... (California collect only one month's premium at time of application)	☐	☐
2. Automatic Bank Account Withdrawal.....	☐	☐
Ongoing Premium Payments (Select option #1a, #1b, or #2)		
1. I want my payments automatically withdrawn from my bank		
a. Choose the day payments will be deducted every month from your bank account.....	1st through the 28th or the last day of every month	1st through the 28th or the last day of every month
OR		
b. Choose the week and weekday that payments will be deducted every month from your bank account..... (For Example: 3rd Wednesday of every month)	**Week (1st, 2nd, 3rd, 4th, last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____	**Week (1st, 2nd, 3rd, 4th, last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____
2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. **Select** frequency of billing).....	**every_____months** Insert 3, 6, or 12	**every_____months** Insert 3, 6, or 12

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON POLICY APPROVAL AND ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is placed inforce, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured(s) will not receive premium billing notices while on this premium payment option. We **CANNOT** establish electronic payments from foreign banks.

Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). **Ongoing deductions will begin once the policy is issued. If the scheduled deduction date begins on a weekend or holiday, the payment will process on the following business day.**

Part II. Payor Information

	Applicant A	Applicant B
1. **Account Owner Name,** if different than applicant's.....	_____	_____
2. If premium is **NOT** paid by Proposed Insured/Insured **(includes spouse or joint-married account)**, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following.		
Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business)	☐	☐
Living Trust	☐	☐
Power of Attorney or legal guardian (documentation required)	☐	☐
Business owned by applicant or applicant's spouse	☐	☐

T01_629_1219

Part III. Account Information

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

Can attach voided check here

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

Name of Financial Institution

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

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

Name as Shown on Account

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

Name of Financial Institution

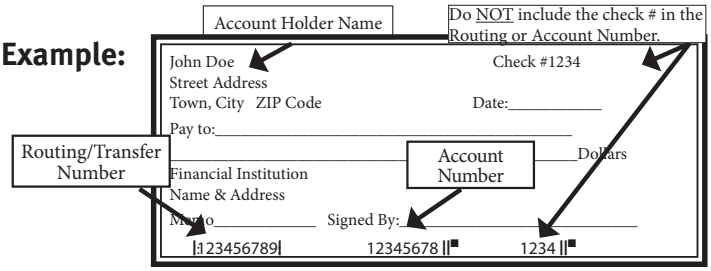
Routing Number (9 digits on lower left side of check)

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

Name as Shown on Account

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

Example:



I authorize Assured Life Association to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. This authorization shall apply to any future payments unless specifically revoked by me. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Assured Life Association any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Assured Life Association may require written confirmation from me within 14 days after my verbal notice.

Applicant A

Authorized Signature as Shown on Account

Date

Applicant B

Authorized Signature as Shown on Account

Date

Assured Life Association

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

FAX Transmittal Cover For Application With Initial Payment By Automated Bank Account Withdrawal

If paying initial premiums by Automated Account Withdrawal, fax this cover and the following documents ONLY to 1-866-422-9139:

- **Method of Payment Form (T01_629_0113)**
- **Application**
- **New Business Documents**

NOTE: Applications faxed to the wrong fax number could cause processing delays. Do NOT send a signed check for the initial premium. Do NOT fax the forms multiple times. If you fax the forms, do NOT mail them.

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.

Assured Life Association

A Fraternal Benefit Society

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 A

- ☐ 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)

_____

_____

_____

Applicant B

- ☐ 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)

_____

_____

_____

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.

✍ _____ _____

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

Assured Life Association, P.O. Box 2397, Omaha, Nebraska 68103-2397

Applicant A	**Applicant B**
Signature	Signature
Date	Date

T01_20

T01_20

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

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

Replacement Notice

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

Premium Receipt

Assured Life Association

A Fraternal Benefit Society

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 A

- ☐ 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)

_____

_____

_____

Applicant B

- ☐ 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)

_____

_____

_____

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.

✍ _____ _____

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

Assured Life Association, P.O. Box 2397, Omaha, Nebraska 68103-2397

Applicant A	**Applicant B**
Signature	Signature
Date	Date

T01_20

T01_20

Assured Life Association

A Fraternal Benefit Society

Premium Receipt

All premiums must be made payable to Assured Life Association.

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

Applicant A

Received from _____

this _____ day of _____ , _____

an application for Form_____Certificate

and/or Riders _____and

Check for _____Dollars.

✍ Agent _____

Applicant B

Received from _____

this _____ day of _____ , _____

an application for Form_____Certificate

and/or Riders _____and

Check for _____Dollars.

✍ Agent _____

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

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

T01_628

T01_628

ASSURED LIFE
ASSOCIATION

PO Box 3169
Englewood, CO 80155-3169
800.777.9777
fraternal@assuredlife.org
www.assuredlife.org

BENEFITS & DISCOUNTS FOR OUR SENIOR MEMBERS

Assured Life has recently partnered with the American Senior Benefits Association® (ASBA®) so that you can get even more out of your Assured Life membership. ASBA is a charitable organization focused on education, philanthropy, and affordable benefits with a substantial community of members. ASBA offers ALA members additional benefits that are very affordable due to its size; a huge value passed on to you. Because ALA has arranged to gift you an ASBA membership for free, here is a peek at some of what you now have available to you:

Complimentary membership in the American Senior Benefits Association (ASBA), a non-political, charitable organization that has given millions of dollars over the years to support worthy causes – a perfect fit that blends well with Assured Life Association's platform.

Access to affordable Dental Insurance - comprehensive dental protection **from ASBA and Ameritas** with no waiting period. From routine care to costly root canals, here are just some of the procedures covered: **Implants | Cleanings | Fillings | Crowns | Dentures | X-rays | Oral Surgery | Root canals & more.**

To learn more about your newly available dental insurance program, call 1.866.692.1980, Mon-Fri 9AM -4PM Eastern.

Access to affordable Vision insurance – with vision protection **from ASBA and VSP** you have the freedom to choose the provider who's right for you, even if they are not in the VSP network. However, when you do visit a VSP provider, your out-of-pocket expenses are lower and there are no claim forms to complete.

To learn more about your newly available vision insurance program, call 1.866.692.1980, Mon-Fri 9AM-4PM Eastern.

Access to Medical Air Services Association (MASA) – Emergency Medical Evacuation – prepaid emergency assistance service **through MASA** whether you are home or traveling. MASA's "Platinum Membership" will provide you with potentially lifesaving, emergency ambulance transportation (via jet, helicopter or ground ambulance) to the nearest medical center that can treat your needs anytime, anywhere. **Visit https://asbaonline.org/index.php/member-programs/insurance to learn more.**

Passport Travel and Entertainment program –valuable savings on dining, shopping, health, travel and many other discounts nationwide. Signup at **https://passportcorporate.com/** with password "ambasavers"

Access to Exclusive "Members Only" OfficeDepot OfficeMax Discounts – Create a new business or personal account to shop online and receive member discounts. Save up to 75% off on the officedepot.com regular prices on preferred products! Free delivery on qualifying orders of $50 or more.

Sign up at https://officediscounts.org/asba/

As a member of Assured Life Association, you are eligible for Hear In America hearing care benefits with no enrollment fees and no premiums. You and your immediate/extended family now have access to free hearing consultations and discounts on high quality hearing aids through their nationwide network of hearing professionals.

Hear In America Member Benefits Include:

1. Free hearing screening for all members and their extended family, even if they live in another household
2. Purchases of hearing aids at set discounted prices (approx. 35-70% off MSRP)
3. 3-year repair warranties
4. 3-year loss and damage coverage
5. 3-year office service (clean, check, adjust)
6. 3 years of free hearing aid batteries mailed from our office to each member
7. Financing is available for those who qualify, including 12 months with no interest.

To learn more or to schedule your free consultation with a provider near you **call (800) 286-6149 to register** and **tell them you are an Assured Life Association member**.

MetLife
MetLife Auto & Home

As a member of Assured Life Association you have access to valuable features and benefits through MetLife Auto & Home Insurance, including special group discounts on auto insurance. Learn more about the benefits of your group auto insurance program from MetLife Auto & Home®. Call today for a free quote! 1-877-491-5089.

NOTE: MetLife Auto & Home is a brand of Metropolitan Property and Casualty Insurance Company and its affiliates: Metropolitan Casualty Insurance Company, Metropolitan Direct Property and Casualty Insurance Company (CA Certificate of Authority: 6730, Warwick, RI), Metropolitan General Insurance Company, Metropolitan Group Property and Casualty Insurance Company (CA COA: 6393; Warwick, RI) and Metropolitan Lloyds Insurance Company of Texas, all with administrative home offices at 700 Quaker Lane, Warwick, RI 02886. Coverage, rates and discounts are available in most states to those who qualify. 1101-0071 © 2011 MetLife Auto & Home L0811200270[exp0714][All States].

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perksconnect℠

As a valued Assured Life Association member, save at thousands of retailers in your neighborhood and around the country with perksconnect. Retailers such as Disney Parks, SeaWorld, Dell, Hyatt Hotels and Budget Rental Cars are just a small sampling of the partners that are offering you everyday savings. Save on discounted gift cards, travel, and event tickets. Registration is simple and FREE. Simply go to assuredlife.perksconnection.com and complete the short form. You can start saving immediately.

PHILIPS
Lifeline

Philips Lifeline is an easy-to-use personal response service that ensures that older adults and those with chronic medical conditions living at home get quick assistance whenever it is needed **at the press of a button**—24 hours a day, 365 days a year—for an affordable monthly fee. The activation fee is waived for benefit and social members and their families—a savings of up to an $80.00 value. Call Assured Life Member Services for more information.

***Important** – Philips is Lifeline available at participating programs only. Not to be combined with any other offer. Applicable tax may be applied. Monthly service and shipping and handling fees apply. Minimum stay on service may be required. Activation fee varies.*

Call 888-763-4161 to find a screening location near you.

life line screening benefit – Life Line Screening is a mobile medical screening service. The Chronic Disease screening package (Carotid Artery, Atrial Fibrillation, Peripheral Arterial Disease, and Abdominal Aortic Aneurysm) plus opt in the Osteoporosis screenings, provides early detection of potential health problems leading to chronic disease. Members can make appointments by calling toll free 888-763-4161 or go on line at https://www.lifelinescreening.com/ala?carousel=0 to schedule a convenient local location. The true value of these screenings enables Members the opportunity to detect life-threatening conditions at an affordable cost of only $135 plus $10 if you would like the Osteoporosis screening.

The Enhanced Benefits Card
EBCcard.com

The Enhanced Benefits Card (EBC Card) is a multi-product discount program available to benefit members and their families. Below is a summary of benefits provided under the EBC Card.

Not available in AK, MT and VT - This is Not Insurance

Prescription Drug Savings	EBC Card members and their families have direct access to prescription discounts. Nearly 9 out of 10 local, regional and national pharmacies will accept your discount card, including all major chains, with pharmacies located in grocery stores and independently owned pharmacies offering the best savings. Members save up to 65% on prescription drugs that are not covered by Medicare, Medicaid or insurance and there are no restrictions or limits on how many times the card can be used.
Dental Savings	EBC Card members have access to over 100,000 dental locations nationwide through the DenteMax dental network. Savings can range up to 40% below usual charges.
Vision Savings	The vision provider network consists of highly qualified eye care professionals who are credentialed and contracted through their nationwide network. Members and their families will receive discounts up to 50% on eye exams (in select areas where approved) and on the purchase of eyewear at over 11,000 optical locations. You also have the opportunity to visit their preferred nationwide LASIK providers. Once you have your ID card, make an appointment with any participating vision provider and show them your Enhanced Benefits Card which includes the vision logo.
Hearing Savings	Through the EBC Card you and your family are eligible for American Hearing Benefits (AHB). This free hearing benefits program gives you access to free hearing consultations and discounts on hearing aids through their nationwide network of hearing professionals. Call 888-890-2875 and a Hearing Care Advisor will assist you in finding an AHB hearing location near you.

How to Get your Free Card:
You can download and print your EBC Card directly from our website. Go to our homepage and select Benefits at the top of the page. Click on “More” in the Important places in this section and then click on “Enhanced Benefits Card” or call our office to get a free ID Card. Present your membership card at any participating provider to receive your savings.

Important To Note: ***This is Not Insurance.*** It is a discount medical program. It does not replace COBRA or any other medical insurance program nor is it a Medicare Part D prescription drug plan. WellCardRx does not qualify for essential coverage under the Affordable Care Act (ACA-ObamaCare). Cardholders are responsible for paying the discounted cost at the time of service from participating providers. WellCardRx has no membership fee nor is participation in any organization or purchase of any good or service required to obtain or use WellCardRx. WellCardRx will not share or sell your personal information. The discount plan organization is Access One Consumer Health, Inc., 84 Villa Road, Greenville, SC, 29615, www.accessonedmpo.com. This program is not available to residents of Montana, but may be used by non-residents at participating Montana providers. **Other state residents: visit www.WellCardRx.com for full disclosure statement**.

The DMPO does make available a list of all program providers which includes their name, city & state, and medical specialty prior to purchase, upon request.

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ADDITIONAL VALUABLE FREE BENEFITS

SENIORS' SCHOLARSHIP – Certificateholders 55 years of age or older who enroll in a short-term learning course are eligible to apply for an Assured Life Association Seniors' Scholarship. Scholarships are awarded in amounts up to $100 each, and are limited to one award per certificateholder per calendar year.

COLLEGE SCHOLARSHIP PROGRAM – **Available to the grandchildren** of certificateholders. Applicant/Student must be a senior in high school, an undergraduate or graduate student, and be taking a minimum of 12 credit hours. Application requirements are published on the Society website each year and due on March 15 of each year. Awards range from $500 to $2,500 and the number of awards available each year varies. Applications are available on our website. Go to our homepage and select Benefits at the top of the page. Select College Scholarship Program from the Benefits page.

SUMMER CAMP GRANTS FOR YOUTH – **Available to grandchildren** of certificateholders. Applicant/Camper must be participating in a camping experience. Applications are available on our website. Go to our homepage and select Benefits at the top of the page. Select Summer Camp Grants from the list under "Important places in this section:" Applications are due May 15 each year.

The Growth Ring Matching Gifts Program

An Individual Benefit Member
Matching Charitable Donations Program!

Benefit members of Assured Life Association are eligible to apply for up to $250 per year in matching charitable gifts to non-profit charities or organizations. Individual donations will be matched with a check issued by Assured Life Association and mailed directly to the charity or organization along with the personal check from the benefit member. If a member has made a donation online, the Society will accept a copy of the receipt of the online donation attached to the matching gift request form in place of a personal check made out to the charity; as long as it occurs in the same calendar year.

Donations can be made in a single amount of $250 or in separate, multiple donations made through-out the year totaling $250; as long as each donation is at least $50.

Matching gifts to a church must be designated for a specific mission of the church rather than a contribution to its general fund or general offering.

Matching Gift request forms can be found on our website. Go to our homepage and select Benefits at the top of the page. Select Charitable Matching Gift Program from the list in the "Important places in this section:". Or you may call our office to request a form be mailed to you.

For questions regarding any of our member benefits, contact our home office.

Please Note: *Member benefits and discounts are not guaranteed and may change at any time without notice. If in question please contact our home office for availability.*