Cigna Medicare Supplement Insurance
American Retirement Life Insurance Company

APPLICATION BOOKLET FOR

KENTUCKY

This packet contains all required forms for application submission. Please complete each form according to the instructions on each page.

- Application
- Comparison statement
- Electronic funds transfer agreement
- MIB pre-notice
- HIPAA notices
- Replacement notice

Note: All Applications outside of OE/GI require a Phone Verification (PV) – Reduce delays and make the PV call at the point-of-sale. **Call our PV Hotline at 866.825.4822 from 7 a.m. to 7 p.m. Central Time**.

Together, all the way.®

Cigna®

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE
American Retirement Life Insurance Company

PO Box 5725, Scranton, PA 18505-5725 • (866) 459-4272

Application is for: ☐ New Business ☐ Reinstatement ☐ Benefit Change

Requested Medicare Supplement effective date* _____ PV Case # _____

*note: if no effective date is requested, we will assign the 1st day of the month following the date of this application

Section I. Applicant Information

First Name	MI	Last Name	Age	Date of Birth (MM/DD/YYYY)	State of Birth

Resident street address *(no PO Box)* _____

City _____ State _____ Zip _____

Mailing address *(if different from above)* _____

City _____ State _____ Zip _____

Phone (_____) _____ **Email address** _____

Social Security No. xxx-xx-xxxx	Medicare Card No.	Sex (M/F)	Rate Class
			☐ Preferred ☐ Standard ☐ Standard II ☐ Standard III

Section II. Coverage Applied for

Policy Form: ☑ **AGENT** Policy Form Series AR-MS-AA-A-GN, AR-MS-AA-F-GN, AR-MS-AA-G-GN, AR-MS-AA-N-GN

Check Plan selected: ☐ Plan A ☐ Plan F ☐ Plan G ☐ Plan N

Section III. Billing

Method *(select one of the following)*:

☐ Bank Draft (complete the Electronic Funds Transfer Agreement)

☐ Direct Bill

Mode *(select one of the following)*:

☐ Monthly (not available with Direct Bill)

☐ Quarterly

☐ Semi-annually

☐ Annually

Section IV. Billing Totals

Initial premium*: ☐ Draft bank account ☐ Check enclosed (payable to ***American Retirement Life Insurance Company***)

*initial premium payment must include the one-time enrollment fee

Modal Premium	$_____
Total Modal Premium (with discount(s) if applicable)	$_____
One-time Enrollment Fee	$ 20
Total Premium with Application	$_____

Section V. Open Enrollment / Guaranteed Issue Questions (MUST BE COMPLETED)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for Guaranteed Issue of a Medicare Supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS (mark YES or NO below with an "X").

To the best of your knowledge:	YES	NO
1. a. Did you turn 65 in the last six (6) months?	☐	☐
b. Did you enroll in Medicare Part B in the last six (6) months?	☐	☐
If YES, what is the effective date? _____		
2. Are you covered for medical assistance through the state Medicaid program? (Note to Applicant: if you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.)	☐	☐
If YES,		
a. will Medicaid pay your premiums for this Medicare Supplement policy?	☐	☐
b. do you receive any benefits from Medicaid ***other than*** payments toward your Medicare Part B premium?	☐	☐
3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO)?	☐	☐
If YES,		
a. fill in your START and END dates below (if you are still covered under this plan, leave the END date blank). START _____ END _____		
b. if you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	☐	☐
c. was this your first time in this type of Medicare plan?	☐	☐
d. did you drop a Medicare Supplement policy to enroll in the Medicare plan?	☐	☐
4. a. Do you have another Medicare Supplement policy in force?	☐	☐
b. If so, with what company and what type plan do you have? _____		
_____		
c. If so, do you intend to replace your current Medicare Supplement policy with this policy?	☐	☐
If existing Medicare Supplement coverage is not to be replaced, this policy cannot be issued.		
5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?	☐	☐
a. If so, with what company and what kind of policy? _____		
_____		
b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave the END date blank.) START _____ END _____		

Section VI. Medicare

	YES	NO
1. Do you now have Medicare Parts A and B?	☐	☐
If YES, give effective date of Part B _____		
2. If Medicare Parts A and B are to be effective at a future date, provide the date both Medicare Parts A and B will be effective _____		

NOTE: Medicare effective date is always the 1st day of the month. Applicant must have both Medicare Parts A and B on the effective date of the policy. If not, coverage cannot be issued.

Section VII. Medical Questions

IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE (BASED ON YOUR ANSWERS IN SECTION(S) V & VI), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.

It is important that you provide truthful and accurate answers to the questions in this section as your answers form the basis of our determination of your eligibility for this coverage. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage.

PART A. MEDICAL QUESTIONS - If the answer to any question in Part A is YES, the Applicant is not eligible for coverage. If you answered NO to all questions in this Section, please continue to Part B and Part C.

		YES	NO
1.	Are you currently confined or scheduled for admission to a nursing facility or assisted living facility or are you receiving home health care services? In the last two (2) years, have you received home health care services for more than three (3) separate periods of care or been confined to a nursing facility for more than 30 days?	☐	☐
2.	Are you currently in the hospital, pending hospital admission, or have you been hospitalized more than two (2) times in the last two (2) years? Have you been treated in an Emergency Room more than two (2) times in the last six (6) months?	☐	☐
3.	Do you currently receive assistance bathing, transferring, toileting, eating, dressing, or are you bedridden or use the assistance of a wheelchair, walker, or motorized mobility aid?	☐	☐
4.	Do you have now or in the last two (2) years have you been treated for or advised by a medical professional to have treatment for the following conditions:		
	a. internal cancer, leukemia, malignant melanoma, Hodgkin's disease, or lymphoma?	☐	☐
	b. heart attack or coronary bypass? (You should answer NO if your only treatment is with maintenance medication.)	☐	☐
	c. congestive heart failure?	☐	☐
	d. multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's disease) or muscular dystrophy?	☐	☐
	e. Paget's disease, rheumatoid arthritis, disabling arthritis, osteoporosis with fractures, or paralysis?	☐	☐
	f. chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant?	☐	☐
	g. diabetes with hypertension requiring three (3) or more medications to control or diabetes requiring more than 50 units of insulin daily to control? (If you do not have diabetes, this question should be answered NO.)	☐	☐
	h. major depression, bipolar disorder, schizophrenia, organic brain disorder, or a paranoid disorder?	☐	☐
	i. unrepaired aneurysm, hemophilia, anemia requiring repeated blood transfusions, or any other blood disorder?	☐	☐
	j. dysplasia of the cervix classified as level 3.0 or higher?	☐	☐
	k. alcohol or drug abuse?	☐	☐
	l. stroke?	☐	☐
	m. terminal illness?	☐	☐
5.	Do you have now or at any time have you been treated for or advised by a medical professional to have treatment for amputation caused by disease or organ transplant other than corneas?	☐	☐
6.	Have medical tests, treatment, therapy, or surgery been advised but not performed or is any surgery anticipated? (This excludes mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only.)	☐	☐
7.	Have you ever been diagnosed with or received treatment from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection?	☐	☐

Section VII. Medical Questions (cont'd.)

PART B. MEDICAL QUESTIONS - The answers to questions in Part B will determine your rate and final determination is subject to the Company's Underwriting review. Please provide complete details as requested below.

8. Height (ft.-in.) _____ Weight (lbs.) _____

9. Do you have now or in the last two (2) years have you been treated for or advised by a medical professional to have treatment for the following conditions:

	YES	NO		YES	NO
a. chronic obstructive pulmonary disease (COPD)?	☐	☐	j. systemic lupus?	☐	☐
b. chronic obstructive lung disease (COLD)?	☐	☐	k. hepatitis other than hepatitis A?	☐	☐
c. emphysema?	☐	☐	l. cirrhosis of the liver?	☐	☐
d. chronic bronchitis?	☐	☐	m. other liver disease?	☐	☐
e. any other chronic lung or respiratory disorder requiring the use of oxygen?	☐	☐	n. cerebral palsy?	☐	☐
			o. Parkinson's disease?	☐	☐
f. diabetes with neuropathy?	☐	☐	p. dementia?	☐	☐
g. diabetes with retinopathy?	☐	☐	q. senility?	☐	☐
h. diabetes with vascular disease?	☐	☐	r. Alzheimer's disease?	☐	☐
i. myasthenia gravis?	☐	☐	s. PSA levels greater than 6.0?	☐	☐

10. Do you have now or in the last two (2) years have you been treated for or advised by a medical professional to have treatment for the following conditions (you should answer NO if your only treatment is with maintenance medication):

	YES	NO		YES	NO
a. angioplasty?	☐	☐	h. stent placement?	☐	☐
b. atherosclerosis or arteriosclerosis?	☐	☐	i. heart valve surgery?	☐	☐
c. peripheral vascular disease?	☐	☐	j. atrial fibrillation?	☐	☐
d. carotid artery disease?	☐	☐	k. irregular heartbeat?	☐	☐
e. coronary artery disease (CAD)?	☐	☐	l. cardiac pacemaker?	☐	☐
f. angina?	☐	☐	m. implantable or subcutaneous defibrillator?	☐	☐
g. cardiomyopathy?	☐	☐	n. transient ischemic attack (TIA)?	☐	☐

	YES	NO
11. Have you used tobacco within the last 12 months?	☐	☐
12. If you have used tobacco within the last 12 months, do you currently:		
a. take maintenance medications for heart or vascular conditions?	☐	☐
b. have diabetes?	☐	☐

PART C. MEDICATIONS

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

Medication	Dates taken	Condition taken for

Section VIII. Important Statements for Applicant to Read

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).

I hereby apply to American Retirement Life Insurance Company for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) no agent has the authority to waive the answer to any questions on the application; (2) no insurance will be effective until (a) a policy has been issued by the Company and (b) the initial premium has been paid; and (3) I have received the Outline of Medicare Supplement Coverage for the policy applied for, the required *Guide to Health Insurance for People with Medicare*, and the MIB Notice.

CAUTION: Please review your answers to the questions on the application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime.

A recorded telephone interview may be used as part of the underwriting on your application for insurance.

Telephone number (_____)_____ Best time to call _____

I understand that the Medicare Supplement policy applied for will not cover loss due to Pre-Existing Condition(s) unless the expense for that loss is incurred more than six (6) months after the effective date of coverage. This provision does not apply if, as of the date of application, you had a Continuous Period of Creditable Coverage which did not expire more than 63 days ago and such coverage, while in force, lasted for at least six (6) months. If, as of the date of application, you had less than six (6) months prior Creditable Coverage, the Pre-Existing Conditions limitation will be reduced by the aggregate amount of Creditable Coverage. This provision does not apply if you are applying for and are issued this policy under Guaranteed Issue status.

Applicant's printed name _____

Signature of Applicant _____ Date _____

Section IX. Agent(s) Certification

Agent(s) shall list any health insurance policies they have sold to the Applicant.

1. List policies sold which are still in force (if this does not apply, state "NONE").

   _____

   _____

2. List policies sold in the past five (5) years which are no longer in force (if this does not apply, state "NONE").

   _____

   _____

	YES	NO
3. Have you reviewed the application for correctness and omissions?	☐	☐

4. I certify that I have provided the Applicant with the following documents:
   a. Application packet (phone sales only)
   b. *Guide to Health Insurance for People with Medicare*
   c. Outline of Medicare Supplement Coverage
   d. MIB Notice
   e. other _____

   I further certify that I have delivered the documents to the Applicant (check all that apply; must select at least one):

   ☐ In person _____ date
   ☐ Mail _____ date
   ☐ Email _____ date
   ☐ Fax _____ date
   ☐ other (explain) _____ _____ date

	YES	NO
5. Was the application completed by you in the Applicant's physical presence?	☐	☐
6. Was the application completed by you over the phone?	☐	☐
7. Do you have knowledge or reason to believe the replacement of existing insurance may be involved?	☐	☐

   If YES, give name of company, reason, and termination date.

   _____

   _____

   _____

I certify that I have interviewed the Applicant, asked all of the questions as written on the application, and I have truly and accurately recorded on the application the information supplied to me by the Applicant.

Printed Name of Licensed Agent	Signature of Licensed Agent	Writing Number	Percentage
Printed Name of 2nd Licensed Agent	Signature of 2nd Licensed Agent	Writing Number	Percentage

AMERICAN RETIREMENT INSURANCE COMPANY
PO Box 5725, Scranton, PA 18505 • 866-459-4272

KENTUCKY MEDICARE SUPPLEMENT COMPARISON STATEMENT

Current Insurance_____ Annual Premium $_____
(Insurer Name)

Proposed Insurance_____ Annual Premium $_____
(Insurer Name)

MEDICARE (PART A): HOSPITAL INSURANCE – COVERED SERVICES PER BENEFIT PERIOD (1)				PRIVATE INSURANCE CHECKLIST	
Service	**Benefit**	**Medicare Pays***	**You Pay***	**Current Insurance Pays Plan ____****	**Proposed Insurance Pays Plan ____**
HOSPITALIZATION Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies	First 60 days	All but $1,484	$1,484		
	61st to 90th day	All but $371 a day	$371 a day		
	91st to 150th day***	All but $742 a day	$742 a day		
	Beyond 150 days	Nothing	All costs		
POSTHOSPITAL SKILLED NURSING FACILITY CARE In a facility approved by Medicare, you must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge (2)	First 20 days	100% of approved amount	Nothing		
	Additional 80 days	All but $185.50 a day	$185.50 a day		
	Beyond 100 days	Nothing	All costs		
HOME HEALTH CARE	Visits limited to medically-necessary skilled care	Full cost of services; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment		
HOSPICE CARE Available to terminally ill	Up to 210 days if doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care	Limited cost sharing for outpatient drugs and inpatient respite care		
BLOOD	Blood	All but first 3 pints	For first 3 pints****		
FOREIGN TRAVEL	Medically-necessary emergency care in a foreign country	Emergency hospital services in qualified Mexican or Canadian hospitals*****	All costs not covered by Medicare		

* These figures are for year **2021** and are subject to change each year.

** If the policy being replaced is not a standardized policy, insert "N/A" after "Plan" and complete this column.

*** 60 reserve days may be used only once; days used are not renewable.

**** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

***** Please refer to your Medicare Handbook for more information.

(1) 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 or skilled nursing facility for 60 days in a row.

(2) Medicare and private Medicare Supplement insurance will not pay for most nursing home care. You pay for custodial care and most care in a nursing home.

MEDICARE (PART B): HOSPITAL INSURANCE – COVERED SERVICES PER CALENDAR PERIOD				PRIVATE INSURANCE CHECKLIST	
Service	**Benefit**	**Medicare Pays**	**You Pay**	**Current Insurance Pays Plan ____***	**Proposed Insurance Pays Plan ____**
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of the hospital	80% of approved amount (after $203 deductible)	$203 deductible** plus 20% of balance of approved amount (plus up to 15% above approved charge)***		
HOME HEALTH CARE	Visits limited to medically necessary skilled care	Full cost of services; 80% of approved amount for durable medical equipment (after $203 deductible)	Nothing for services; 20% of approved amount for durable medical equipment (after $203 deductible)		
AT-HOME RECOVERY BENEFIT	Short-term at-home assistance with activities of daily living****	Nothing	All costs		
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary	80% of approved amount (after $203 deductible)	Subject to deductible plus 20% of approved amount		
BLOOD	Blood	80% of approved amount (after $203 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount (after $203 deductible)*****		
PREVENTIVE CARE – PATIENT EDUCATION	Annual physical exam, preventive testing, influenza vaccines	Screening pap smears once every 24 months; screening mammograms every 12 months	All cost not covered by Medicare		
OUTPATIENT PRESCRIPTION DRUGS	Outpatient prescription drugs	Nothing	All costs		
FOREIGN TRAVEL	Medically-necessary emergency care in a foreign country	Doctor and ambulance service in Canada and Mexico if in connection with covered inpatient	All costs not covered by Medicare		
OTHER******					

* If the policy being replaced is not a standardized policy, insert "N/A".

** Once you have had $203 of expense for covered services in year **2021**, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

*** YOU PAY FOR charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered.

**** At-home recovery benefits must be received in conjunction with Medicare-approved home health care benefits.

***** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

****** Use this area to compare pre-standardization and/or innovative benefits.

TO APPLICANT: Do not sign this form unless it has been explained to you.

Applicant	Date	Agent	Date

NOTICE TO AGENT/INSURER: This form is to be retained by the replacing insurer and attached to the replacement policy.

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

AMERICAN RETIREMENT LIFE INSURANCE COMPANY • PO BOX 5725 • SCRANTON, PA 18505

Proposed Insured's Name		**Policy Number (if available)**
Financial Institution Name and Telephone Number		
Financial Institution Address		
9-digit Routing Number	**Account Number**	**Requested Withdrawal Date (1st - 28th)**

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

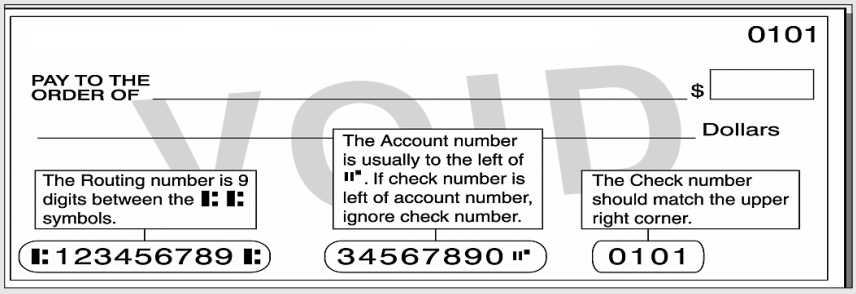
Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.



APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to American Retirement Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize American Retirement Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event American Retirement Life Insurance Company mistakenly deposits funds into my account, I authorize American Retirement Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR AMERICAN RETIREMENT LIFE INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by American Retirement Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by American Retirement Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by American Retirement Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured) **Payor's Address**

Print name of Depositor (as it appears on account) **Signature of Depositor** **Date**

MIB, Inc., Pre-Notice

AMERICAN RETIREMENT LIFE INSURANCE COMPANY
PO Box 5725, Scranton, PA 18505-5725 • 866-459-4272

Information regarding your insurability will be treated as confidential. American Retirement Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

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

American Retirement Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates as described below.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information. However, MIB, Inc., information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB, Inc.
4. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
5. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually-transmitted diseases unless otherwise restricted by state law.
6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 5700, Scranton, PA 18505-5700.
7. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
8. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
9. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
10. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

_____

_____ _____

Applicant's Name **Name of Applicant's Personal Representative, if applicable**

_____ _____

Applicant's Social Security Number **Relationship of Personal Representative to the Applicant**

_____ _____

Signature of Applicant **Date** **Signature of Personal Representative** **Date**

_____

Signature of Company's Agent **Date**

A signed copy of this form will be provided with the policy if issued and any other time upon request.

AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER'S PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES ("Authorization")

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization at any time, except to the extent that action has been taken by the Company in reliance on this Authorization, by sending a written revocation to the Company's Privacy Steward at PO Box 5700, Scranton, PA 18505-5700.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing this Authorization.
6. I understand that if the person or entity that receives my Protected Health Information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this Authorization is as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this Authorization. This Authorization will remain in effect for two (2) years from the day my policy(ies) is terminated or the day I revoke my permission.
8. By providing my telephone number(s) on the attached application for insurance, I consent to receive calls, texts, or autodialed or prerecorded telemarketing messages from Cigna and its affiliates.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer's behalf:

_____

_____ _____

Consumer's Name **Name of Consumer's Personal Representative, if applicable**

_____ _____

Signature of Consumer **Date** **Relationship of Personal Representative to the Consumer**

_____ _____

Signature of Company's Agent **Date** **Signature of Personal Representative** **Date**

A signed copy of this form will be provided to you.

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the American Retirement Life Insurance Company (ARLIC) with the application.

A copy of this form must also be left with the Applicant.

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

AMERICAN RETIREMENT LIFE INSURANCE COMPANY
PO Box 5725, Scranton, PA 18505 • 866-459-4272

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

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

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, OR BROKER

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement coverage is being purchased for the following reason (check one):

☐ additional benefits

☐ no change in benefits, but lower premiums

☐ fewer benefits and lower premiums

☐ my plan has outpatient drug coverage and I am enrolling in Part D

☐ disenrollment from a Medicare Advantage Plan – please explain reason for disenrollment _____

☐ other (please specify) _____

NOTES:

1. If the Issuer of the Medicare Supplement policy being applied for does not or is otherwise prohibited from imposing pre-existing condition limitations, please skip to note 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the Application concerning your medical and health history. Failure to include all material medical information on an Application may provide a basis for the Company to deny any future claims and to refund your premiums as though your policy had never been in force. After the Application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE YOU WANT TO KEEP IT.

_____ _____

Agent's Signature **Applicant's Signature**

_____ _____

Type or Print Name and Address of Agent/Broker **Date**

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the American Retirement Life Insurance Company (ARLIC) with the application.

A copy of this form must also be left with the Applicant.

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

AMERICAN RETIREMENT LIFE INSURANCE COMPANY
PO Box 5725, Scranton, PA 18505 • 866-459-4272

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

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

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, OR BROKER

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement coverage is being purchased for the following reason (check one):

☐ additional benefits

☐ no change in benefits, but lower premiums

☐ fewer benefits and lower premiums

☐ my plan has outpatient drug coverage and I am enrolling in Part D

☐ disenrollment from a Medicare Advantage Plan – please explain reason for disenrollment _____

☐ other (please specify) _____

NOTES:

1. If the Issuer of the Medicare Supplement policy being applied for does not or is otherwise prohibited from imposing pre-existing condition limitations, please skip to note 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the Application concerning your medical and health history. Failure to include all material medical information on an Application may provide a basis for the Company to deny any future claims and to refund your premiums as though your policy had never been in force. After the Application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE YOU WANT TO KEEP IT.

_____ _____

Agent's Signature **Applicant's Signature**

_____ _____

Type or Print Name and Address of Agent/Broker **Date**