

Cigna Medicare Supplement Insurance
American Retirement Life Insurance Company

**APPLICATION BOOKLET
FOR
KANSAS**

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

- › **Application**
- › **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.®



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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 Underwritten Disabled (underage) OE GI 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)	Household Discount*
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you used tobacco within the last 12 months? Yes No | Rate Class: Preferred Standard Standard II Standard III

*If another member of your household is applying for or currently has a Medicare Supplement plan with American Retirement Life Insurance Company or an affiliated company, you may qualify for a Household Discount; see the Outline of Coverage for details. Please provide the name and Social Security number of the individual(s) living at your current address.

Spouse/Household Member Name			Spouse/Household Member SSN
First Name	MI	Last Name	XXX-XX-XXXX

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	\$ _____
(if Household Discount, then multiply modal premium by 0.93)	
Total Modal Premium (with discount(s) if applicable)	\$ _____
One-time Enrollment Fee	\$ <u>20</u>
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 age 65 in the last six (6) months? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Did you enroll in Medicare Part B in the last six (6) months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.) ... | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, | | |
| a. will Medicaid pay your premiums for this Medicare Supplement policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. do you receive any benefits from Medicaid <i>other than</i> payments toward your Medicare Part B premium? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. was this your first time in this type of Medicare plan? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. did you drop a Medicare Supplement policy to enroll in the Medicare plan? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. a. Do you have another Medicare Supplement policy in force? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 1 st 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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
b. heart attack or coronary bypass? (You should answer NO if your only treatment is with maintenance medication.) .	<input type="checkbox"/>	<input type="checkbox"/>
c. congestive heart failure?	<input type="checkbox"/>	<input type="checkbox"/>
d. multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's disease) or muscular dystrophy?	<input type="checkbox"/>	<input type="checkbox"/>
e. Paget's disease, rheumatoid arthritis, disabling arthritis, osteoporosis with fractures, or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
f. chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>
h. major depression, bipolar disorder, schizophrenia, organic brain disorder, or a paranoid disorder?	<input type="checkbox"/>	<input type="checkbox"/>
i. unrepaired aneurysm, hemophilia, anemia requiring repeated blood transfusions, or any other blood disorder? ...	<input type="checkbox"/>	<input type="checkbox"/>
j. dysplasia of the cervix classified as level 3.0 or higher?	<input type="checkbox"/>	<input type="checkbox"/>
k. alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
l. stroke?	<input type="checkbox"/>	<input type="checkbox"/>
m. terminal illness?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
6. In the past five (5) years, 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.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been diagnosed with or received medical advice or 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?	<input type="checkbox"/>	<input type="checkbox"/>

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)? ... | <input type="checkbox"/> | <input type="checkbox"/> | j. systemic lupus? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. chronic obstructive lung disease (COLD)? | <input type="checkbox"/> | <input type="checkbox"/> | k. hepatitis other than hepatitis A? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. emphysema? | <input type="checkbox"/> | <input type="checkbox"/> | l. cirrhosis of the liver? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. chronic bronchitis? | <input type="checkbox"/> | <input type="checkbox"/> | m. other liver disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. any other chronic lung or respiratory disorder requiring the use of oxygen? | <input type="checkbox"/> | <input type="checkbox"/> | n. cerebral palsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. diabetes with neuropathy? | <input type="checkbox"/> | <input type="checkbox"/> | o. Parkinson's disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. diabetes with retinopathy? | <input type="checkbox"/> | <input type="checkbox"/> | p. dementia? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. diabetes with vascular disease? | <input type="checkbox"/> | <input type="checkbox"/> | q. senility? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. myasthenia gravis? | <input type="checkbox"/> | <input type="checkbox"/> | r. Alzheimer's disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | s. PSA levels greater than 6.0? | <input type="checkbox"/> | <input type="checkbox"/> |
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? | <input type="checkbox"/> | <input type="checkbox"/> | h. stent placement? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. atherosclerosis or arteriosclerosis? | <input type="checkbox"/> | <input type="checkbox"/> | i. heart valve surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. peripheral vascular disease? | <input type="checkbox"/> | <input type="checkbox"/> | j. atrial fibrillation? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. carotid artery disease? | <input type="checkbox"/> | <input type="checkbox"/> | k. irregular heartbeat? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. coronary artery disease (CAD)? | <input type="checkbox"/> | <input type="checkbox"/> | l. cardiac pacemaker? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. angina? | <input type="checkbox"/> | <input type="checkbox"/> | m. implantable or subcutaneous defibrillator? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. cardiomyopathy? | <input type="checkbox"/> | <input type="checkbox"/> | n. transient ischemic attack (TIA)? | <input type="checkbox"/> | <input type="checkbox"/> |
11. If you have used tobacco within the last 12 months, do you currently:
- | | | |
|---|--------------------------|--------------------------|
| | YES | NO |
| a. take maintenance medications for heart or vascular conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |

PART C. MEDICATIONS

12. 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

AGENT NOTES - Please provide any other information that you believe may assist in our underwriting determination:

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 reinstated 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 reinstated 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 reinstated 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 reinstated 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 presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

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 _____

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)):

- | | |
|--|---|
| <input type="checkbox"/> New authorization | <input type="checkbox"/> Change in checking/savings account |
| <input type="checkbox"/> Change in financial institution | <input type="checkbox"/> 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.

0101

PAY TO THE ORDER OF _____ \$ _____

Dollars

The Routing number is 9 digits between the ■■■ symbols.
■ 123456789 ■

The Account number is usually to the left of "■". If check number is left of account number, ignore check number.
34567890 ■

The Check number should match the upper right corner.
0101

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 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.

