HEARTLAND NATIONAL LIFE INSURANCE COMPANY
Home Office: Indianapolis, Indiana 46280
Medicare Supplement Administrative Office: PO Box 2878, Salt Lake City, Utah 84110-2878
Telephone 877-431-7371

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

A. PLAN INFORMATION (TO BE COMPLETED BY AGENT)

APPLICANT A	APPLICANT B
Plan Applied for: ☐ A ☐ C ☐ G ☐ N	Plan Applied for: ☐ A ☐ C ☐ G ☐ N
Requested Effective Date _____/_____/_____	Requested Effective Date _____/_____/_____
Deliver Policy to: ☐ Applicant A ☐ Agent	Deliver Policy to: ☐ Applicant B ☐ Agent

B. APPLICANT INFORMATION

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.

APPLICANT A	APPLICANT B
Name (First/Middle Initial/Last)	Name (First/Middle Initial/Last)
Residence Address	Residence Address
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
Telephone ( ) --	Telephone ( ) --
E-mail Address	E-mail Address
Current Age Date of Birth ____/____/____	Current Age Date of Birth ____/____/____
Social Security # ______-_____-________	Social Security # ______-_____-________
☐ Male Height ____ft ____in	☐ Male Height ____ft ____in
☐ Female Weight _____lbs	☐ Female Weight _____lbs
Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months? ☐ Yes ☐ No	Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months? ☐ Yes ☐ No

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 _____/_____/_____	Medicare Part A Effective Date _____/_____/_____
If you are not covered under Medicare Part A, what is your eligibility date _____/_____/_____	If you are not covered under Medicare Part A, what is your eligibility date _____/_____/_____
Medicare Part B Effective Date _____/_____/_____	Medicare Part B Effective Date _____/_____/_____
If you are not covered under Medicare Part B, what is your eligibility date _____/_____/_____	If you are not covered under Medicare Part B, what is your eligibility date _____/_____/_____

D. HOUSEHOLD PREMIUM DISCOUNT

(You may be eligible for a policy with a lower premium rate based on the statements in this section.)

	Applicant: A	B
Do you currently live with your spouse, who owns or is issued a Medicare supplement policy with us or do you currently have a household resident (at least one, no more than three) with whom you have continuously resided for the last 12 months and at least one owns or is issued a Medicare supplement policy with us? If "YES", please fill out the following information about the household resident, unless both applicants are both applying for coverage on this application.	☐ Y ☐ N	☐ Y ☐ N

Name (First/Middle Initial/Last)	Date of Birth / /
Street Address	
City, State, ZIP	

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 "Y for YES" or "N for NO" with an "X" to the questions below.

To the best of your knowledge and belief: **Applicant: A B**

1. Are you covered for medical assistance through the state Medicaid program? ☐ Y ☐ N ☐ Y ☐ N
   - A. If yes: Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ 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
2. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.

   Applicant A start date _____/_____/_____ End date _____/_____/_____

   Applicant B start date _____/_____/_____ End date _____/_____/_____

   - A. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Y ☐ N ☐ Y ☐ N
   - B. Was this your first time in this type of Medicare plan? ☐ Y ☐ N ☐ Y ☐ N
   - C. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ Y ☐ N ☐ Y ☐ N
3. Do you have another Medicare Supplement policy in force? ☐ Y ☐ N ☐ Y ☐ N
   - A. If so, with what company, and what plan do you have?

     Applicant A - Company ______________________________ Plan __________________

     Applicant B - Company ______________________________ Plan __________________
   - B. If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Y ☐ N ☐ Y ☐ N
4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ☐ Y ☐ N ☐ Y ☐ N
   - A. If so, with what company, and what kind of policy?

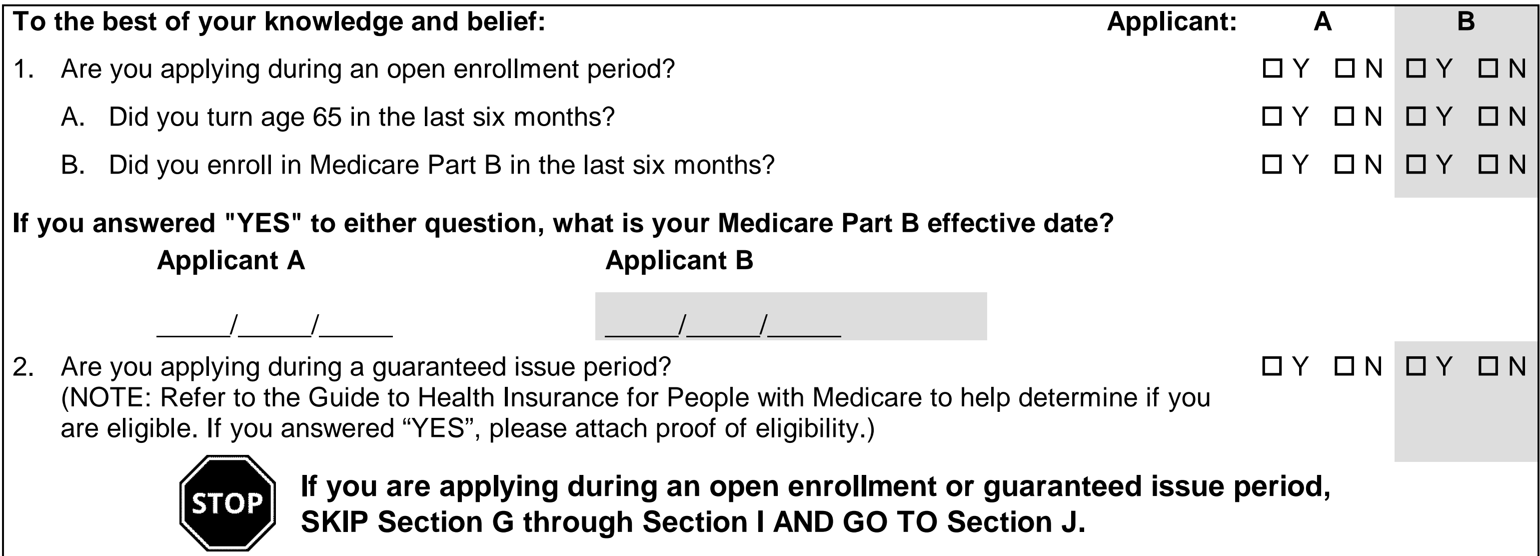
     Applicant A - Company ______________________________ Plan __________________

     Applicant B - Company ______________________________ Plan __________________
   - B. What are your start and end dates of coverage under the other policy? (if you are still covered under the other policy, leave "End" blank.)

     Applicant A start date _____/_____/_____ End date _____/_____/_____

     Applicant B start date _____/_____/_____ End date _____/_____/_____

F. ELIGIBILITY QUESTIONS



To the best of your knowledge and belief:	Applicant: A	B
1. Are you applying during an open enrollment period?	☐ Y ☐ N	☐ Y ☐ N
A. Did you turn age 65 in the last six months?	☐ Y ☐ N	☐ Y ☐ N
B. Did you enroll in Medicare Part B in the last six months?	☐ Y ☐ N	☐ Y ☐ N

If you answered "YES" to either question, what is your Medicare Part B effective date?

Applicant A	Applicant B
_____/_____/_____	_____/_____/_____

	A	B
2. Are you applying during a guaranteed issue period? (NOTE: Refer to the Guide to Health Insurance for People with Medicare to help determine if you are eligible. If you answered "YES", please attach proof of eligibility.)	☐ Y ☐ N	☐ Y ☐ N

STOP **If you are applying during an open enrollment or guaranteed issue period, SKIP Section G through Section I AND GO TO Section J.**

G. MEDICAL QUESTIONS (PART A)

For all plans, please answer ALL questions.
NOTE: An interviewer may call to confirm and verify the information you provide on this application.
(If "YES" is the answer to questions 1-8, that person is not eligible for coverage.)

To the best of your knowledge and belief:	Applicant: A	B
1. Are you currently confined to a wheelchair or any motorized mobility device?	☐ Y ☐ N	☐ Y ☐ N
2. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?	☐ Y ☐ N	☐ Y ☐ N
3. Have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease (Stages 3, 4 or 5), 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), Huntington's disease, or cerebral palsy?	☐ Y ☐ N	☐ Y ☐ N
E. Systemic lupus, scleroderma or myasthenia gravis?	☐ Y ☐ N	☐ Y ☐ N
F. Chronic hepatitis or cirrhosis?	☐ Y ☐ N	☐ Y ☐ N
4. Have you had an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea implants)?	☐ Y ☐ N	☐ Y ☐ N
5. Do you have Osteoporosis, and as a result, experienced a fracture?	☐ Y ☐ N	☐ Y ☐ N
6. Do you have diabetes with complications including retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart disorder or any kidney disease?	☐ Y ☐ N	☐ Y ☐ N
7. Do you have an implanted cardiac defibrillator?	☐ Y ☐ N	☐ Y ☐ N
8. Have you been diagnosed by a medical professional as having ARC or AIDS caused by the HIV infection?	☐ Y ☐ N	☐ Y ☐ N

H. MEDICAL QUESTIONS (PART B)

(If "YES" is answered to any of the following questions 9-12 that person MAY not be eligible for coverage and is subject to an underwriting review.) If you would like consideration to be given to an application that contains a "Yes" answer to any question in Part B, attach an explanation stating how long the condition has existed and how it is being controlled.

To the best of your knowledge and belief:	Applicant: A	B
9. 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

H. MEDICAL QUESTIONS (PART B) - CONTINUED

To the best of your knowledge and belief:	Applicant: A	B
9. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
C. Alcoholism or drug abuse?	☐ Y ☐ N	☐ Y ☐ N
D. Any mental or nervous disorder requiring treatment (including hospital confinement)?	☐ 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 joint replacement?	☐ Y ☐ N	☐ Y ☐ N
10. Do you have diabetes with high blood pressure and have you:		
A. Taken more than two medications for either condition (insulin dependent or oral medications)?	☐ Y ☐ N	☐ Y ☐ N
B. Had any changes in your medications within the past two years?	☐ Y ☐ N	☐ Y ☐ N
11. Have you been hospital confined three or more times in the past two years for a same or similar condition?	☐ 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 (excluding HIV/AIDS)?	☐ Y ☐ N	☐ Y ☐ N

NOTE: Please verify the completeness and accuracy of the above statements as they may impact claim payment.

I. MEDICATION INFORMATION

(If you are applying for ANY plan OUTSIDE of an open enrollment or guaranteed issue period, please answer the following question.

If "YES", list all over-the-counter or prescription medications you are currently taking or have been prescribed in the last 2 years

To the best of your knowledge and belief:	Applicant: A	B
1. Are you currently taking, or have you been prescribed during the previous 2 years, any prescription drugs or over-the-counter medications?	☐ Y ☐ N	☐ Y ☐ N

APPLICANT A

Medication Name (copy of 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	

APPLICANT B

Medication Name (copy of 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	

J. PREMIUM AND METHOD OF PAYMENT (All checks will be processed as EFT (Electronic Funds Transfer) from you bank)

Applicant A		Applicant B	
Modal Premium	$______________	Modal Premium	$ ______________
Policy Fee	$25.00	Policy Fee	$25.00
Household Discount 7%	$______________	Household Discount 7%	$ ______________
Total Submitted Premium	$______________	Total Submitted Premium	$ ______________

APPLICANT A

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

☐ I authorize Bank Draft Payments. Account Type: ☐ Checking ☐ Savings Amount to be drafted: $____________

Bank Routing # (9 digits): ____________________ Bank Account # (do not include check #): ________________________________ Select Bank Draft Day: ____/____/____

Bank Name: ____

Name(s) of Depositor(s): ____

Signature of Depositor: ____ Date: ____/____/____

Please include a voided check on a separate sheet of paper.

APPLICANT B

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

☐ I authorize Bank Draft Payments. Account Type: ☐ Checking ☐ Savings Amount to be drafted: $____________

Bank Routing # (9 digits): ____________________ Bank Account # (do not include check #): ________________________________ Select Bank Draft Day: ____/____/____

Bank Name: ____

Name(s) of Depositor(s): ____

Signature of Depositor: ____ Date: ____/____/____

Please include a voided check on a separate sheet of paper.

K. IMPORTANT STATEMENTS

- You do not need more than one Medicare Supplement Insurance 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 Insurance Policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance 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 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 suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy 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).

L. AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO HEARTLAND NATIONAL LIFE INSURANCE COMPANY

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Heartland National Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Heartland National Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Heartland National Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Heartland National Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Heartland National Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Heartland National Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 2878, Salt Lake City, Utah 84110-2878. I understand that such revocation will not have any effect on actions Heartland National Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

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

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 policy benefits can start no earlier than my Medicare effective date, my first month's premium payment has been received and/or processed and my application has been approved by Heartland National Life Insurance Company. I acknowledge that I have received or been given access to review: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Applicant A signature | Date signed

X ______________________________ | ______________

Applicant B signature | Date signed

X ______________________________ | ______________

M. AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant(s) has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policies you have sold to the Applicant that are still in force.

2. List any other health insurance policies you have sold to the Applicant in the past five (5) years that are no longer in force.

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

Agent #1 Signature Date

Agent #1 Name (please print) Agent # Split %

Agent #2 Signature Date

Agent #2 Name (please print) Agent # Split %

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
Home Office: Indianapolis, Indiana 46280
Medicare Supplement Administrative Office: PO Box 2878, Salt Lake City, Utah 84110-2878
Telephone 877-431-7371

GUARANTEED ISSUE ELIGBILITY FOR MEDICARE SUPPLEMENT INSURANCE

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997. An eligible person is an individual described in any of the following paragraphs:

- ☐ Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan (eligible for Plans A or C); or

- ☐ Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual (eligible for Plans A or C); or

- ☐ Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual (eligible for Plans A or C); or

- ☐ Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation (eligible for Plans A or C); or

- ☐ Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment (eligible for the same Plan you terminated with us, or, if that Plan is no longer available, Plans A or C); or

- ☐ Upon first becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months (eligible for all plans available from us); or

- ☐ Enrolled in a Medicare Part D Plan during the initial Part D enrollment period while enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and terminate the Medicare Supplement policy (eligible for Plans A or C).

Documentation of these events must be submitted with this Application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: Indianapolis, Indiana 46280

Medicare Supplement Administrative Office: PO Box 2878, Salt Lake City, Utah 84110-2878

I, The Insurance Agent or Broker Certify:

That, I am an insurance agent or broker.

That, I am making the solicitation or sale on behalf of Heartland National Life Insurance Company.

That, I have no connection or affiliation with, and are not in any way sponsored by, the federal or state government, the social security administration, the Centers for Medicare and Medicaid services, or the Department of Health and Human Services.

Agent Name: ______________________ Phone #: ______________

Agent Address: ______________________

Agency Name: ______________________ Phone #: ______________

Agency Address: ______________________

I, The Applicant understand that I have a right to:

Verify the information above by contacting the Ohio department of insurance;
Ohio Department of Insurance
50 W. Town Street, 3rd Floor-Suite 300
Columbus, OH 43215
(800) 686-1526

Contact the agent or broker making the solicitation or sale at both an address and telephone number provided by the agent or broker;

Contact the insurance company, insurance companies or the insurance company administrative office on behalf of which the solicitation or sale was made at an address and telephone number provided by the agent or broker;

Pay my premium(s) directly to the insurance company's designated administrator, if I purchase a Medicare supplemental insurance policy.

Heartland National Life Insurance Company
Medicare Supplement Administrative Office
PO Box 2878, Salt Lake City, Utah 84110-2878

I, The Applicant, acknowledge the receipt of this form.

Date: ______________ Applicant Signature: ______________________

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

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
PO Box 2878, Salt Lake City, Utah 84110-2878

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 coverage and replace it with a policy to be issued by Heartland National Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your policy or Medicare Advantage coverage only if after due consideration and acceptance by the replacing insurer, you find that purchase of this Medicare Supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

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

- ☐ Additional Benefits.
- ☐ Same benefits but lower premium.
- ☐ 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) ____

I call to your attention the following item for your consideration: 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 issuer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

______________________________	______________________________
Producer's Signature	Producer's PRINTED Name and Address
______________________________	______________________________
Applicant A's Signature	Date
______________________________	______________________________
Applicant B's Signature	Date

Producer: If this replacement notice is necessary, have the insured complete and sign this form and leave it with the Applicant.

Replaced Company Name: ____

Replaced Company Address: ____

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

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
PO Box 2878, Salt Lake City, Utah 84110-2878

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You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your policy or Medicare Advantage coverage only if after due consideration and acceptance by the replacing insurer, you find that purchase of this Medicare Supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

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

- ☐ Additional Benefits.
- ☐ Same benefits but lower premium.
- ☐ 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) ____

I call to your attention the following item for your consideration: 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 issuer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

________________________________	________________________________
Producer's Signature	Producer's PRINTED Name and Address
________________________________	________________________________
Applicant A's Signature	Date
________________________________	________________________________
Applicant B's Signature	Date

Producer: If this replacement notice is necessary, have the insured complete and sign this form and leave it with the Applicant.

Replaced Company Name: ____

Replaced Company Address: ____

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Outline of Medicare Supplement Coverage Benefit Plans A, C, G and N
Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F and high deductible F.

✂ Only Medicare Supplement Benefit Plans A, C, G and N are offered by Insurance Company.

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A✂	B	D	G[1]✂	K	L	M	N✂	C✂	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)	✓	✓	✓	✓	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 2020[2]					$5880 [2]	$2940 [2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2340 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.

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Heartland National Life Insurance Company
Standard Plans FEMALE Rates - Annual
For use in zip codes: 450-454
One-Time Certificate Fee of $25

Attained	Non-Tobacco				Tobacco			
Age	A	C	G	N	A	C	G	N
65	104.17	136.91	104.69	89.92	119.79	157.44	120.39	103.40
66	104.17	136.91	104.69	89.92	119.79	157.44	120.39	103.40
67	104.17	136.91	104.69	89.92	119.79	157.44	120.39	103.40
68	104.17	136.91	104.69	89.92	119.79	157.44	120.39	103.40
69	106.58	139.43	107.11	91.86	122.56	160.34	123.18	105.64
70	109.06	142.11	109.61	93.93	125.42	163.42	126.05	108.01
71	112.99	146.70	113.56	97.35	129.94	168.70	130.60	111.95
72	116.92	151.29	117.51	100.78	134.46	173.98	135.14	115.89
73	121.30	155.88	121.46	104.20	139.49	179.27	139.68	119.83
74	126.50	162.88	127.29	109.24	145.47	187.31	146.39	125.63
75	131.82	170.06	133.27	114.41	151.60	195.56	153.26	131.57
76	135.56	176.01	138.20	118.82	155.90	202.41	158.92	136.64
77	139.39	181.66	143.24	123.03	160.30	208.91	164.72	141.48
78	143.30	187.14	148.40	127.14	164.79	215.21	170.66	146.21
79	147.29	192.72	153.69	131.32	169.38	221.63	176.74	151.02
80	151.37	198.40	159.10	135.58	174.08	228.16	182.96	155.92
81	154.96	204.45	164.59	140.25	178.21	235.12	189.28	161.29
82	158.63	210.62	170.22	145.03	182.42	242.21	195.75	166.78
83	162.36	216.91	175.97	149.89	186.72	249.45	202.37	172.38
84	166.18	223.33	181.86	154.86	191.10	256.83	209.14	178.09
85	170.07	230.21	187.89	160.17	195.58	264.74	216.07	184.19
86	172.92	236.19	192.66	164.77	198.85	271.62	221.56	189.48
87	175.80	242.53	197.52	169.64	202.17	278.91	227.14	195.08
88	178.74	249.02	202.47	174.61	205.55	286.37	232.84	200.80
89	182.17	255.64	208.02	179.70	209.49	293.98	239.22	206.65
90	185.66	262.40	213.70	184.90	213.51	301.76	245.75	212.63
91	189.09	270.03	219.50	190.72	217.46	310.53	252.43	219.32
92	192.59	277.86	225.44	196.69	221.48	319.54	259.26	226.19
93	196.15	287.02	231.53	203.63	225.58	330.07	266.25	234.17
94	199.78	296.45	237.75	210.78	229.75	340.92	273.41	242.39
95	203.48	306.18	244.13	218.16	234.00	352.10	280.74	250.88
96	207.55	313.52	249.01	223.39	238.68	360.55	286.36	256.90
97	211.70	321.05	253.99	228.75	243.45	369.21	292.09	263.07
98	215.93	328.75	259.07	234.24	248.32	378.07	297.93	269.38
99	220.25	336.64	264.25	239.87	253.29	387.14	303.89	275.85

Heartland National Life Insurance Company
Standard Plans MALE Rates - Annual
For use in zip codes: 450-454
One-Time Certificate Fee of $25

Attained Age	Non-Tobacco A	Non-Tobacco C	Non-Tobacco G	Non-Tobacco N	Tobacco A	Tobacco C	Tobacco G	Tobacco N
65	119.79	157.44	120.39	103.40	137.76	181.06	138.45	118.91
66	119.79	157.44	120.39	103.40	137.76	181.06	138.45	118.91
67	119.79	157.44	120.39	103.40	137.76	181.06	138.45	118.91
68	119.79	157.44	120.39	103.40	137.76	181.06	138.45	118.91
69	122.56	160.34	123.18	105.64	140.95	184.39	141.65	121.48
70	125.42	163.42	126.05	108.01	144.24	187.94	144.96	124.22
71	129.94	168.70	130.60	111.95	149.43	194.01	150.18	128.75
72	134.46	173.98	135.14	115.89	154.63	200.08	155.41	133.28
73	139.49	179.27	139.68	119.83	160.41	206.15	160.63	137.81
74	145.47	187.31	146.39	125.63	167.29	215.41	168.34	144.48
75	151.60	195.56	153.26	131.57	174.33	224.90	176.25	151.31
76	155.90	202.41	158.92	136.64	179.28	232.77	182.76	157.14
77	160.30	208.91	164.72	141.48	184.34	240.24	189.43	162.70
78	164.79	215.21	170.66	146.21	189.51	247.49	196.26	168.14
79	169.38	221.63	176.74	151.02	194.79	254.87	203.25	173.67
80	174.08	228.16	182.96	155.92	200.19	262.39	210.40	179.30
81	178.21	235.12	189.28	161.29	204.94	270.39	217.67	185.49
82	182.42	242.21	195.75	166.78	209.78	278.54	225.11	191.80
83	186.72	249.45	202.37	172.38	214.72	286.86	232.72	198.23
84	191.10	256.83	209.14	178.09	219.77	295.35	240.51	204.80
85	195.58	264.74	216.07	184.19	224.92	304.45	248.48	211.82
86	198.85	271.62	221.56	189.48	228.68	312.36	254.79	217.91
87	202.17	278.91	227.14	195.08	232.50	320.75	261.21	224.34
88	205.55	286.37	232.84	200.80	236.38	329.32	267.76	230.92
89	209.49	293.98	239.22	206.65	240.91	338.08	275.11	237.65
90	213.51	301.76	245.75	212.63	245.53	347.02	282.61	244.53
91	217.46	310.53	252.43	219.32	250.07	357.11	290.29	252.22
92	221.48	319.54	259.26	226.19	254.70	367.47	298.15	260.12
93	225.58	330.07	266.25	234.17	259.41	379.58	306.19	269.29
94	229.75	340.92	273.41	242.39	264.21	392.06	314.43	278.75
95	234.00	352.10	280.74	250.88	269.10	404.92	322.85	288.51
96	238.68	360.55	286.36	256.90	274.48	414.63	329.31	295.44
97	243.45	369.21	292.09	263.07	279.97	424.59	335.90	302.53
98	248.32	378.07	297.93	269.38	285.57	434.78	342.62	309.79
99	253.29	387.14	303.89	275.85	291.28	445.21	349.47	317.22

Heartland National Life Insurance Company
Standard Plans FEMALE Rates - Annual
For use in zip codes: 436, 440-445
One-Time Certificate Fee of $25

Attained	Non-Tobacco				Tobacco			
Age	A	C	G	N	A	C	G	N
65	109.37	143.75	109.92	94.41	125.78	165.32	126.41	108.57
66	109.37	143.75	109.92	94.41	125.78	165.32	126.41	108.57
67	109.37	143.75	109.92	94.41	125.78	165.32	126.41	108.57
68	109.37	143.75	109.92	94.41	125.78	165.32	126.41	108.57
69	111.90	146.40	112.47	96.45	128.69	168.36	129.34	110.92
70	114.52	149.21	115.09	98.62	131.69	171.59	132.36	113.42
71	118.64	154.03	119.24	102.22	136.44	177.14	137.13	117.55
72	122.77	158.86	123.39	105.82	141.18	182.68	141.89	121.69
73	127.36	163.68	127.53	109.41	146.46	188.23	146.66	125.83
74	132.82	171.03	133.66	114.71	152.74	196.68	153.70	131.91
75	138.41	178.56	139.93	120.13	159.17	205.34	160.92	138.15
76	142.34	184.81	145.10	124.76	163.69	212.53	166.87	143.47
77	146.36	190.74	150.40	129.18	168.31	219.35	172.96	148.56
78	150.46	196.50	155.82	133.49	173.03	225.97	179.19	153.52
79	154.65	202.36	161.37	137.89	177.85	232.71	185.58	158.57
80	158.94	208.32	167.05	142.36	182.78	239.57	192.11	163.71
81	162.71	214.67	172.82	147.27	187.12	246.87	198.74	169.36
82	166.56	221.15	178.73	152.28	191.54	254.32	205.54	175.12
83	170.48	227.76	184.77	157.39	196.05	261.92	212.49	181.00
84	174.49	234.49	190.95	162.60	200.66	269.67	219.60	186.99
85	178.57	241.72	197.28	168.17	205.36	277.98	226.87	193.40
86	181.56	248.00	202.29	173.01	208.80	285.20	232.63	198.96
87	184.59	254.66	207.39	178.12	212.28	292.86	238.50	204.83
88	187.68	261.47	212.59	183.34	215.83	300.69	244.48	210.84
89	191.28	268.42	218.42	188.68	219.97	308.68	251.19	216.99
90	194.94	275.52	224.38	194.14	224.18	316.85	258.04	223.27
91	198.55	283.53	230.48	200.25	228.33	326.06	265.05	230.29
92	202.22	291.75	236.72	206.53	232.55	335.51	272.22	237.50
93	205.96	301.37	243.10	213.81	236.86	346.57	279.57	245.88
94	209.77	311.27	249.64	221.32	241.24	357.97	287.09	254.51
95	213.65	321.48	256.33	229.07	245.70	369.71	294.78	263.42
96	217.93	329.20	261.46	234.56	250.61	378.58	300.68	269.75
97	222.28	337.10	266.69	240.19	255.63	387.67	306.69	276.22
98	226.73	345.19	272.02	245.96	260.74	396.97	312.82	282.85
99	231.26	353.48	277.46	251.86	265.95	406.50	319.08	289.64

Heartland National Life Insurance Company
Standard Plans MALE Rates - Annual
For use in zip codes: 436, 440-445
One-Time Certificate Fee of $25

Attained Age	Non-Tobacco				Tobacco			
	A	C	G	N	A	C	G	N
65	125.78	165.32	126.41	108.57	144.65	190.11	145.37	124.86
66	125.78	165.32	126.41	108.57	144.65	190.11	145.37	124.86
67	125.78	165.32	126.41	108.57	144.65	190.11	145.37	124.86
68	125.78	165.32	126.41	108.57	144.65	190.11	145.37	124.86
69	128.69	168.36	129.34	110.92	147.99	193.61	148.74	127.56
70	131.69	171.59	132.36	113.42	151.45	197.33	152.21	130.43
71	136.44	177.14	137.13	117.55	156.91	203.71	157.69	135.18
72	141.18	182.68	141.89	121.69	162.36	210.09	163.18	139.94
73	146.46	188.23	146.66	125.83	168.43	216.46	168.66	144.70
74	152.74	196.68	153.70	131.91	175.65	226.18	176.76	151.70
75	159.17	205.34	160.92	138.15	183.05	236.14	185.06	158.87
76	163.69	212.53	166.87	143.47	188.25	244.41	191.90	164.99
77	168.31	219.35	172.96	148.56	193.56	252.25	198.90	170.84
78	173.03	225.97	179.19	153.52	198.98	259.87	206.07	176.54
79	177.85	232.71	185.58	158.57	204.53	267.62	213.41	182.35
80	182.78	239.57	192.11	163.71	210.20	275.51	220.92	188.27
81	187.12	246.87	198.74	169.36	215.18	283.91	228.55	194.76
82	191.54	254.32	205.54	175.12	220.27	292.47	236.36	201.38
83	196.05	261.92	212.49	181.00	225.46	301.21	244.36	208.15
84	200.66	269.67	219.60	186.99	230.76	310.12	252.54	215.04
85	205.36	277.98	226.87	193.40	236.16	319.67	260.91	222.41
86	208.80	285.20	232.63	198.96	240.11	327.98	267.53	228.80
87	212.28	292.86	238.50	204.83	244.13	336.79	274.28	235.56
88	215.83	300.69	244.48	210.84	248.20	345.79	281.15	242.47
89	219.97	308.68	251.19	216.99	252.96	354.98	288.86	249.53
90	224.18	316.85	258.04	223.27	257.81	364.37	296.75	256.75
91	228.33	326.06	265.05	230.29	262.58	374.97	304.80	264.83
92	232.55	335.51	272.22	237.50	267.44	385.84	313.06	273.13
93	236.86	346.57	279.57	245.88	272.38	398.56	321.50	282.76
94	241.24	357.97	287.09	254.51	277.42	411.66	330.15	292.69
95	245.70	369.71	294.78	263.42	282.55	425.16	339.00	302.94
96	250.61	378.58	300.68	269.75	288.21	435.37	345.78	310.21
97	255.63	387.67	306.69	276.22	293.97	445.81	352.69	317.65
98	260.74	396.97	312.82	282.85	299.85	456.51	359.75	325.28
99	265.95	406.50	319.08	289.64	305.85	467.47	366.94	333.08

Heartland National Life Insurance Company
Standard Plans FEMALE Rates - Annual
Zip Codes: 430-435, 437-439, 446-449, 455-459
A one-time $25 policy fee applies to each application

Attained	Non-Tobacco				Tobacco			
Age	A	C	G	N	A	C	G	N
65	95.83	125.96	96.31	82.72	110.21	144.85	110.76	95.13
66	95.83	125.96	96.31	82.72	110.21	144.85	110.76	95.13
67	95.83	125.96	96.31	82.72	110.21	144.85	110.76	95.13
68	95.83	125.96	96.31	82.72	110.21	144.85	110.76	95.13
69	98.05	128.27	98.54	84.51	112.76	147.51	113.32	97.19
70	100.34	130.74	100.84	86.41	115.39	150.35	115.97	99.37
71	103.96	134.96	104.48	89.56	119.55	155.21	120.15	103.00
72	107.57	139.19	108.11	92.72	123.71	160.07	124.33	106.62
73	111.59	143.41	111.74	95.87	128.33	164.92	128.51	110.25
74	116.38	149.85	117.11	100.51	133.83	172.33	134.67	115.58
75	121.28	156.45	122.61	105.26	139.47	179.92	141.00	121.05
76	124.72	161.93	127.14	109.31	143.43	186.22	146.21	125.71
77	128.24	167.13	131.78	113.19	147.47	192.19	151.55	130.16
78	131.83	172.17	136.53	116.97	151.61	197.99	157.01	134.51
79	135.51	177.30	141.39	120.81	155.83	203.90	162.60	138.94
80	139.26	182.53	146.37	124.73	160.15	209.91	168.32	143.44
81	142.57	188.10	151.43	129.03	163.95	216.31	174.14	148.39
82	145.94	193.77	156.60	133.42	167.83	222.84	180.09	153.44
83	149.38	199.56	161.89	137.90	171.78	229.49	186.18	158.59
84	152.88	205.46	167.31	142.47	175.82	236.28	192.41	163.84
85	156.47	211.79	172.86	147.35	179.94	243.56	198.79	169.46
86	159.08	217.30	177.25	151.59	182.95	249.89	203.83	174.33
87	161.74	223.13	181.72	156.07	186.00	256.60	208.97	179.47
88	164.44	229.09	186.27	160.64	189.11	263.46	214.21	184.74
89	167.59	235.18	191.38	165.32	192.73	270.46	220.09	190.12
90	170.81	241.41	196.60	170.11	196.43	277.62	226.09	195.62
91	173.97	248.43	201.94	175.46	200.06	285.69	232.23	201.78
92	177.19	255.63	207.41	180.96	203.76	293.97	238.52	208.10
93	180.46	264.06	213.00	187.34	207.53	303.66	244.95	215.44
94	183.80	272.74	218.73	193.92	211.37	313.65	251.54	223.00
95	187.20	281.68	224.60	200.71	215.28	323.93	258.28	230.81
96	190.95	288.44	229.09	205.52	219.59	331.71	263.45	236.35
97	194.76	295.37	233.67	210.45	223.98	339.67	268.72	242.02
98	198.66	302.45	238.34	215.51	228.46	347.82	274.09	247.83
99	202.63	309.71	243.11	220.68	233.03	356.17	279.57	253.78

Heartland National Life Insurance Company
Standard Plans MALE Rates - Annual
For use in zip codes: 430-435, 437-439, 446-449, 455-459
One-Time Certificate Fee of $25

Attained Age	Non-Tobacco A	Non-Tobacco C	Non-Tobacco G	Non-Tobacco N	Tobacco A	Tobacco C	Tobacco G	Tobacco N
65	110.21	144.85	110.76	95.13	126.74	166.58	127.37	109.40
66	110.21	144.85	110.76	95.13	126.74	166.58	127.37	109.40
67	110.21	144.85	110.76	95.13	126.74	166.58	127.37	109.40
68	110.21	144.85	110.76	95.13	126.74	166.58	127.37	109.40
69	112.76	147.51	113.32	97.19	129.67	169.64	130.32	111.76
70	115.39	150.35	115.97	99.37	132.70	172.90	133.36	114.28
71	119.55	155.21	120.15	103.00	137.48	178.49	138.17	118.45
72	123.71	160.07	124.33	106.62	142.26	184.08	142.98	122.62
73	128.33	164.92	128.51	110.25	147.58	189.66	147.78	126.78
74	133.83	172.33	134.67	115.58	153.91	198.18	154.88	132.92
75	139.47	179.92	141.00	121.05	160.39	206.91	162.15	139.21
76	143.43	186.22	146.21	125.71	164.94	214.15	168.14	144.57
77	147.47	192.19	151.55	130.16	169.59	221.02	174.28	149.69
78	151.61	197.99	157.01	134.51	174.35	227.69	180.56	154.69
79	155.83	203.90	162.60	138.94	179.21	234.48	186.99	159.78
80	160.15	209.91	168.32	143.44	184.17	241.40	193.57	164.96
81	163.95	216.31	174.14	148.39	188.54	248.76	200.26	170.65
82	167.83	222.84	180.09	153.44	193.00	256.26	207.10	176.45
83	171.78	229.49	186.18	158.59	197.55	263.92	214.10	182.38
84	175.82	236.28	192.41	163.84	202.19	271.72	221.27	188.42
85	179.94	243.56	198.79	169.46	206.92	280.09	228.60	194.87
86	182.95	249.89	203.83	174.33	210.39	287.37	234.41	200.47
87	186.00	256.60	208.97	179.47	213.90	295.09	240.32	206.40
88	189.11	263.46	214.21	184.74	217.47	302.98	246.34	212.45
89	192.73	270.46	220.09	190.12	221.64	311.03	253.10	218.64
90	196.43	277.62	226.09	195.62	225.89	319.26	260.01	224.97
91	200.06	285.69	232.23	201.78	230.07	328.54	267.07	232.04
92	203.76	293.97	238.52	208.10	234.33	338.07	274.30	239.31
93	207.53	303.66	244.95	215.44	238.66	349.21	281.70	247.75
94	211.37	313.65	251.54	223.00	243.08	360.69	289.27	256.45
95	215.28	323.93	258.28	230.81	247.57	372.52	297.03	265.43
96	219.59	331.71	263.45	236.35	252.52	381.46	302.97	271.80
97	223.98	339.67	268.72	242.02	257.57	390.62	309.03	278.32
98	228.46	347.82	274.09	247.83	262.73	399.99	315.21	285.00
99	233.03	356.17	279.57	253.78	267.98	409.59	321.51	291.84

PREMIUM INFORMATION

We, Heartland National Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age.

Tobacco/Non-Tobacco

Standard premiums are based on use of tobacco; Preferred premiums are based on non-usage of tobacco.

HOUSEHOLD PREMIUM DISCOUNT

You are eligible for a Household Premium Discount if: (1) You reside with Your spouse, who owns or is issued a Medicare supplement policy written by Heartland National Life Insurance Company, or (2) for the past year You have resided with at least one, but no more than three, other adults who are age 18 and older who own or are issued a Medicare supplement policy written by Heartland National Life Insurance Company. If you live with another adult who is your legal spouse, we will waive both the one-year requirement and the age 18 requirement. For the purpose of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in your state of residence. We may request additional documentation to determine eligibility.

Your premium will be reduced by the percentage shown on the Policy Schedule page. Your Policy's Household Premium Discount will be removed if the other policyholder chooses to terminate his or her Medicare supplement policy or no longer resides with you.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your Policy's most important features. The Policy is your insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and Heartland National Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your Policy, you may return it to: Heartland National Life Insurance Company, Medicare Supplement Administration, PO Box 2878, Salt Lake City, Utah 84110-2878. If you send the Policy back to us within 30 days after you receive it, we will treat the Policy 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 policy and are sure you want to keep it.

NOTICE

This Policy may not fully cover all of your medical costs. Neither Heartland National Life Insurance Company 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 and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new Policy, be sure to answer truthfully and completely all questions about your medical and health history. Heartland National Life Insurance Company may cancel your Policy 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.

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 PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1408	$0	$1408 (Part A deductible)
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $704 a day	$704 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 thru 100th day	All but $176 a day	$0	Up to $176 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, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy'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 $198 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 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 $198 of Medicare Approved Amounts *	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C
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 PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $704 a day	$704 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 thru 100th day	All but $176 a day	Up to $176 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, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy'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 C (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

* Once you have been billed $198 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 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 $198 of Medicare Approved Amounts *	$0	$198 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
First 3 pints	$0	All costs	$0
Next $198 of Medicare Approved Amounts*	$0	$198 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Part A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $198 of Medicare Approved Amounts*	$0	$198 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

Other Benefits - Not Covered by Medicare

SERVICES	MEDICARE PAYS	PLAN 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

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 PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $704 a day	$704 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 thru 100th day	All but $176 a day	Up to $176 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, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy'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 $198 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 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 $198 of Medicare Approved Amounts *	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Part A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

Other Benefits - Not Covered by Medicare

SERVICES	MEDICARE PAYS	PLAN 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

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 PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $704 a day	$704 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 thru 100th day	All but $176 a day	Up to $176 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, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy'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.

MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

* Once you have been billed $198 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 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 $198 of Medicare Approved Amounts *	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Part A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

Other Benefits - Not Covered by Medicare

SERVICES	MEDICARE PAYS	PLAN 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

Premium Calculation

Medicare Supplement Plan ________________

	Steps	Example - *Information displays is for illustrational purposes only*	Enrollee
#1	**Enrollee Age** **Enrollee Zip Code**	65 12345	
#2	**Premium** Premium shown in Outline of Coverage	$150.000	
#3	**Household Premium Discount** If the applicant lives with his or her spouse, or partner in a civil union, or has continuously lived with at least one but no more than 3 other adults for at least a year, multiply premium by .93	$150.00 x .93 = $139.50	
#4	**Payment Options** Modal Premiums – To determine other pay schedules, multiply the monthly premium by: Annual = MBD x 12 Semi-Annual = MBD x 6 Quarterly= MBD x 3		

Receipt

Receipt

Please Note: All premium checks must be made payable to Heartland National Life Insurance Company. ***Do not make checks payable to the insurance agent or leave the payee line blank.***

Received from ____ the sum of $ __________________ for ____________________________ months premium, with this application. If for any reason the application is not approved and the policy is not issued, this premium is to be refunded. No liability is created or assumed by the Company, except for refund of this premium, until the policy applied for has been issued.

Date Receipt and Outline of Coverage was prepared _________________________, 20 ____________

by ____

Agent's Signature

Heartland National Life Insurance Company, PO Box 2878, Salt Lake City, UT 84110-2878