Atlantic Coast Life Insurance Company
Administrative Office
P.O. Box 27248 Salt Lake City, Utah 84127-0248
Phone: 1-844-442-3847

Application For:	☐ **Medicare Supplement Coverage** ☐ **Medicare Supplement Conversion; Policy Number** ____________

Agent Name(s) / Agent Number (s):

SECTION 1: PLAN (to be completed by Agent)

NOTE: For ALL sections, ONLY complete the Applicant B information if second applicant also applying

APPLICANT A	APPLICANT B
Medicare Supplement Plan ☐ A ☐ C* ☐ F* ☐ G ☐ N	**Medicare Supplement Plan** ☐ A ☐ C* ☐ F* ☐ G ☐ N
*Plans C & F are only available for those first eligible prior to January 1, 2020	*Plans C & F are only available for those first eligible prior to January 1, 2020
Requested Effective Date:	Requested Effective Date:
Mail Policy To: ☐ Insured ☐ Agent	Mail Policy To: ☐ Insured ☐ Agent

SECTION 2: APPLICANT INFORMATION - PLEASE ANSWER ALL QUESTIONS COMPLETELY

APPLICANT A	APPLICANT B
Name (First/Middle/Last)	Name (First/Middle/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
Home Phone No.	Home Phone No.
E-mail Address	E-mail Address
Date of Birth Current Age	Date of Birth Current Age
☐ Male ☐ Female	☐ Male ☐ Female
Social Security No.	Social Security No.
Medicare Beneficiary Identifier	Medicare Beneficiary Identifier

SECTION 3: PLEASE ANSWER ALL QUESTIONS COMPLETELY. PLEASE MARK "YES" OR "NO" WITH AN "X" TO THE QUESTIONS BELOW.

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.

Question	Applicant A	Applicant B
Have you received a copy of the Guide to Health Insurance for People with Medicare and the of the **Outline of Coverage**?	☐ Yes ☐ No	☐ Yes ☐ No
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A?	☐ Yes ☐ No	☐ Yes ☐ No
If "YES," what is your Part A effective date? ______ (Applicant A) / ______ (Applicant B)		
If "NO," what is your eligibility date? ______ (Applicant A) / ______ (Applicant B)		
2. Are you covered under Medicare Part B or have you enrolled in Medicare Part B in the last six months?	☐ Yes ☐ No	☐ Yes ☐ No
If "YES," what is your Part B effective date? ______ (Applicant A) / ______ (Applicant B)		
If "NO," indicate date you plan to enroll. ______ (Applicant A) / ______ (Applicant B)		
3.Are you younger than 65 and eligible for Medicare by reason of disability as defined by federal law?	☐ Yes ☐ No	☐ Yes ☐ No
(a) Are you enrolled in Medicare Part A and Part B?	☐ Yes ☐ No	☐ Yes ☐ No
If "YES," what is the effective date of: Part A ______ (Applicant A) / ______ (Applicant B) Part B ______ (Applicant A) / ______ (Applicant B)		
4. Have you turned 65 in the last six months or will you turn 65 within the next six months?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 4: FOR YOUR PROTECTION, we ask the following questions about insurance policies or certificates you may have.

Question	Applicant A	Applicant B
To the Best of Your Knowledge:		
1. Are you applying during a Guaranteed Issue period?	☐ Yes ☐ No	☐ Yes ☐ No
(NOTE: If the answer above is "YES," please attach proof of eligibility.)		
2. Do you have another Medicare Supplement insurance policy or certificate inforce?	☐ Yes ☐ No	☐ Yes ☐ No
(a) If "YES," with what company and what plan do you have?		

APPLICANT A	APPLICANT B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date	Issue Date

Question	Applicant A	Applicant B
(b) If "YES," do you intend to replace your current Medicare Supplement policy/certificate with this policy?	☐ Yes ☐ No	☐ Yes ☐ No
(c) If "YES," indicate termination date: ______ (Applicant A) / ______ (Applicant B)		
(d) **If "YES," have you received a copy of the replacement notice?**	☐ Yes ☐ No	☐ Yes ☐ No
3. 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.		
START ______ END ______ (Applicant A) START ______ END ______ (Applicant B)		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No
(b) **If "YES," have you received a copy of the replacement notice?**	☐ Yes ☐ No	☐ Yes ☐ No
(c) Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
(d) Did you drop a Medicare Supplement policy/certificate to enroll in this Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
(e) Is your former Medicare Supplement policy/certificate still available?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 4: CONTINUED

	Applicant A	Applicant B
4. Have you had coverage under any health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare Supplement plan.) (a) If "YES," with what company and what kind of policy/certificate? (List below.)	☐ Yes ☐ No	☐ Yes ☐ No

APPLICANT A		APPLICANT B	
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate

(b) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank.

START ____________ END ____________ (Applicant A) START ____________ END ____________ (Applicant B)

	Applicant A	Applicant B
5. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program," and have not met your "Share of Cost," please answer "NO" to this question.) **If "YES,"**	☐ Yes ☐ No	☐ Yes ☐ No
(a) Will Medicaid pay your premiums for this Medicare Supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 5: BILLING INFORMATION

APPLICANT A	APPLICANT B
Initial Premium $ ________ = $ ________ Med Supp Premium / Total Premium Amount Collected: $__________ Renewal Premium: $ ________ Initial Premium Draft Date: ____________	Initial Premium $ ________ = $ ________ Med Supp Premium / Total Premium Amount Collected: $__________ Renewal Premium: $ ________ Initial Premium Draft Date: ____________
Select Premium Payment Option: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly Bank Draft (direct monthly not available)	Select Premium Payment Option: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly Bank Draft (direct monthly not available)

I would like my monthly premium payment to come from my (check one) on the ____________ day of the month:
☐ **Checking (Please attach a voided check)** ☐ **Savings**
Please ask your financial institution to verify that this Monthly Bank Draft will be accepted, and that the information below is correct.

Financial Institution Name:	Phone #:
Financial Institution Address:	
Transit Routing # (9 digits):	Account #:

I hereby request and authorize Atlantic Coast Life Insurance Company to initiate a charge to my account at the named Financial Institution to pay the premium(s) due, after the first premium has been paid, on any policy issued in connection with this application. The term "charge" shall include items initiated by electronic means, checks, drafts or any other order. I have the right to stop payment of a charge by giving notice to Atlantic Coast Life Insurance Company or the Financial Institution in such time as to afford a reasonable opportunity to act prior to charging my account. I agree that Atlantic Coast Life Insurance Company's rights in respect to each charge shall be the same as if it were a check made payable to Atlantic Coast Life Insurance Company and personally signed by me. If any charge is dishonored for any reason, Atlantic Coast Life Insurance Company shall not be under any liability even though such dishonor results in the forfeiture of insurance.

______________________________ ______________________________ ____________
Signature as it appears on financial institution records Print name of account owner (if other than proposed insured) Date

SECTION 6: HOUSEHOLD PREMIUM DISCOUNT INFORMATION

You may be eligible for a policy with a lower premium rate based on your answers to the questions in this section.	**APPLICANT A**	**APPLICANT B**
1. Do you currently have a household resident (at least one, no more than 3) who is age 50 or older:		
a. With whom you have continuously resided for the past 12 months, or to whom you are married; or	☐ Yes ☐ No	☐ Yes ☐ No
b. Who has an existing Medicare Supplement policy, or is applying for such a policy, with Atlantic Coast Life Insurance Company?	☐ Yes ☐ No	☐ Yes ☐ No
2. If you answered "YES" to Question 1a or 1b above, please fill out the following information about the household resident, except if both applicants are applying for coverage on this application.		

Name (First/Middle/Last):		
Policy Number:	Social Security Number:	Date of Birth:
Name (First/Middle/Last):		
Policy Number:	Social Security Number:	Date of Birth:

SECTION 7:
- **During Open Enrollment or a Guaranteed Issue period, SKIP SECTION 7 and GO TO SECTION 8.**
- **If NOT during Open Enrollment or a Guaranteed Issue period, PLEASE ANSWER ALL QUESTIONS.**

If either you or Applicant B answer "YES" to any of the following questions, 1-13, that person is not eligible for Medicare Supplement coverage.

Applicant	**Applicant B**
Height/Weight: Ft. __________ In. _________ Lbs. __________	Height/Weight: Ft. __________ In. _________ Lbs. __________

Question	**Applicant**	**Applicant B**
1. Are you currently hospitalized, in a nursing home or assisted living facility, receiving hospice or home healthcare; or, are you bedridden, wheelchair bound, using oxygen or require the use of a motorized device?	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, or other chronic lung disorder including shortness of breath, or have you been hospitalized for a chronic lung disorder in the past 7 years?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you been diagnosed with Parkinson's Disease, systemic lupus, scleroderma, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with related fractures, cirrhosis or chronic hepatitis in the past 7 years?	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you been diagnosed with or taken medication for Alzheimer's Disease, dementia or any other cognitive disorder, or have you consulted a physician for memory loss in the past 7 years?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV) in the past 7 years?	☐ Yes ☐ No	☐ Yes ☐ No
6. Has a physician advised you to have cataract surgery in the next 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
7. Within the past 5 years have you been treated for or been advised by a physician to have treatment for internal cancer, including, but not limited to, breast, ovarian, lung, liver, kidney, bladder, prostate, pancreas, stomach, colon, pituitary, brain, thyroid, mouth, Hodgkins or other lymphoma, leukemia or any form of malignant skin cancer including melanoma (excluding basal cell, actinic keratosis or squamous cell carcinoma)?	☐ Yes ☐ No	☐ Yes ☐ No
8. Have you been hospital confined three or more times in the last 24 months?	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you had an organ transplant or been advised by a physician to have an organ transplant in the past 7 years?	☐ Yes ☐ No	☐ Yes ☐ No
10. In the past 7 years, have you been medically diagnosed with, treated for, or had surgery for chronic kidney disease, kidney failure, or had kidney disease requiring dialysis?	☐ Yes ☐ No	☐ Yes ☐ No
11. In the past 7 years have you had diabetes that has ever required more than 50 units of insulin daily?	☐ Yes ☐ No	☐ Yes ☐ No
12.Have you had diabetes that is treated by medication or diet in the past 7 years? If **"YES",** have you	☐ Yes ☐ No	☐ Yes ☐ No
had any known symptoms or known indications of complications due to diabetes as listed below?	☐ Yes ☐ No	☐ Yes ☐ No
A. Neuropathy or numbness in your hands, feet or legs?	☐ Yes ☐ No	☐ Yes ☐ No
B. Retinopathy or eye disorder (other than cataracts)?	☐ Yes ☐ No	☐ Yes ☐ No
C. Kidney Disease?	☐ Yes ☐ No	☐ Yes ☐ No
D. Skin ulcers or had an amputation?	☐ Yes ☐ No	☐ Yes ☐ No
E. Heart disorder, poor circulation or peripheral vascular disease, history of stroke or TIA?	☐ Yes ☐ No	☐ Yes ☐ No
13. Are you currently receiving or been recommended to receive, any drug treatment administered through an IV treatment, infusion or injected by a medical professional (excluding B-12 or allergy shots or injectable osteoporosis medications)?	☐ Yes ☐ No	☐ Yes ☐ No
14. Within the past 24 months have you been treated for or been advised by a physician to have treatment for:		
A. Bowel obstruction, Crohn's disease or ulcerative colitis, or have lost more than 10% of your body weight in the past 12 months (other than intentional weight loss)?	☐ Yes ☐ No	☐ Yes ☐ No
B. Alcohol or drug use, mental or nervous disorder requiring psychiatric care?	☐ Yes ☐ No	☐ Yes ☐ No
C. Heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or cardiomyopathy, stroke, Transient Ischemic Attack (TIA) or heart rhythm disorder?	☐ Yes ☐ No	☐ Yes ☐ No
15. Have you used tobacco in any form, an electronic cigarette (e-cig) or other nicotine delivery product in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
16. Are you applying for coverage because you have been diagnosed or treated for End Stage Renal Disease (ESRD) or Kidney Disease requiring dialysis in the last 7 years?	☐ Yes ☐ No	☐ Yes ☐ No

ADDITIONAL INFORMATION: PART 7- CONTINUED HEALTH/MEDICAL QUESTIONS

Question	Applicant	Applicant B
17. Within the past 24 months have you been treated for degenerative bone disease, crippling/ disabling, rheumatoid arthritis, spinal stenosis or have you been advised to have a joint replacement or have you had an amputation caused by disease?	☐Yes ☐No	☐Yes ☐No
18. Within the past 24 months have you consulted a doctor or other health care practitioner and been told to have a further examination, diagnostic test or surgery which has not yet been performed or for which the results are not yet known?	☐Yes ☐No	☐Yes ☐No
19. Are you taking or have you taken any prescription or over-the-counter medications within the past 24 months? If "YES," please list the drug and the condition.	☐Yes ☐No	☐Yes ☐No

Primary Care Physician/Clinic	Date Last Seen (within the last 2yrs)	
Name	Address	Phone

Applicant (please attach a separate sheet if needed)		**Applicant B** (please attach a separate sheet if needed)
	Medication Name (copy off pharmacy label)	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Frequency and Dosage	
	Diagnosis/Condition	

IF ADDITIONAL SPACE IS REQUIRED ATTACH SEPARATE SHEET

SECTION 8: PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- 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 coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing the 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 re-instituted 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 re-instituted policy will not have outpatient prescription drug coverage and shall not provide for any waiting period with respect to treatment of preexisting conditions, 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 re-instituted 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 re-instituted policy will not have outpatient prescription drug coverage and shall not provide for any waiting period with respect to treatment of preexisting conditions, 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 understand a telephone interview may be necessary to verify or supplement information given to Atlantic Coast Life Insurance Company on this application. A photocopy of this form will be as valid as the original; this Authorization and Acknowledgment will be valid for 24 months after it is signed.

ANY PERSON WHO, WITH THE 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 MAY HAVE VIOLATED STATE LAW.

I wish to apply for a Medicare Supplement insurance policy. I acknowledge that I received a copy of the **Guide to Health Insurance for People with Medicare.** 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 the policy applied for will not take effect until it is issued by Atlantic Coast Life Insurance Company and all of the following requirements are met: (a) the policy is delivered and accepted, each applicant will receive a separate policy; (b) my policy benefits start no earlier than my Medicare effective date; (c) the first full premium has been paid according to the mode of payment specified in the application, and (d) my application has been approved by Atlantic Coast Life Insurance Company.

You or any individual authorized to act on your behalf is entitled to receive a copy of this authorization form.

The undersigned applicant and agent CERTIFY that the applicant has read, or had read to him, 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.

Dated at ______________________________, on ______________________, ____________
City, State — Month — Day — Year

______________________________ ______________________________
Applicant A's Signature — Applicant B's Signature (if applying)

Premium Must Accompany Application

I/We certify that during an interview with the proposed applicant, I/We have truly and accurately recorded in the application the information supplied by the applicant.

______________________________ ______________________________
(Signature of Licensed Producer) — (Signature of Licensed Producer)

______________________________ ______________________________
PRODUCER NUMBER / (STAMP) — PRODUCER NUMBER / (STAMP)

SECTION 9: AGENT SUPPLEMENT

List any other health insurance policies/certificates you have sold to the applicant.
(a) List policies/certificates sold which are still inforce.

APPLICANT A	APPLICANT B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage	Effective Date of Coverage

(b) List policies/certificates sold in the past five (5) years, which are no longer inforce.

APPLICANT A	APPLICANT B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage	Effective Date of Coverage

SECTION FOR ADDITIONAL COMMENTS

APPLICANT A (please attach a separate sheet if needed)	**APPLICANT B** (please attach a separate sheet if needed)

MEDICARE SUPPLEMENT INITIAL PREMIUM RECEIPT

MAKE CHECK PAYABLE TO: Atlantic Coast Life Insurance Company

Received from ______________________ (Proposed Insured) for a policy with Atlantic Coast Life Insurance Company (the Company), and $ __________ for the initial premium. In the event the application is not accepted by the Company, the above amount will be refunded. No obligation is incurred by the Company unless said application is approved by the Company and a policy is issued.

______________________ **Agent's Name (please print)**	______________________ **Agent's Signature**	__________ **Date**

LEAVE WITH APPLICANT