aetna®

American Continental Insurance Company

Administrative Office
800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067

Application for Medicare Supplement Insurance
from American Continental Insurance Company

- Print clearly and use blue or black ink.
- If only one applicant, just complete **Applicant A** information.
- Complete all required sections of the application. Any incomplete or missing information could delay processing of your application.

1. Applicant A information

Write the name as stated on the Medicare card. Provide a copy of the Medicare card with the application if possible.

Full name of proposed insured *First, M.I., Last*

Address | Phone

City | State | Zip

E-mail | Social Security Number

Write the date of birth that is on the birth certificate.

Birth date *mm/dd/yyyy* | Age

Height *Feet and inches* | Weight *Pounds* | ○ Male ○ Female

Include any letters associated with the Medicare number and in the appropriate position. If applicant has not received a Medicare card yet, put "No Medicare number yet".

Are you a legal resident of the United States? ○ Yes ○ No

Have you used any form of tobacco in the past 12 months? ○ Yes ○ No

Medicare card number

Date enrolled in: Medicare Part A | Medicare Part B

Applicant B information

Review instructions above before completing.

Full name of proposed insured *First, M.I., Last*

Address | Phone

City | State | Zip

E-mail | Social Security Number

Birth date *mm/dd/yyyy* | Age

Height *Feet and inches* | Weight *Pounds* | ○ Male ○ Female

Are you a legal resident of the United States? ○ Yes ○ No

Have you used any form of tobacco in the past 12 months? ○ Yes ○ No

Medicare card number

Date enrolled in: Medicare Part A | Medicare Part B

For Agent Use Only

Check if application is for:

Applicant A	○ Open Enrollment	○ Guaranteed Issue
Applicant B	○ Open Enrollment	○ Guaranteed Issue

Deliver policy(ies) to: ○ Agent ○ Applicant(s)

2. Plan and premium information

You have a choice among several payment options or modes for paying your premium (annual, semi-annual, quarterly and monthly electronic funds transfer).

If applying for household discount: provide the discounted and non-discounted premium amounts.

Household premium discount eligibility information

To be eligible for the household discount as outlined below, please answer the applicable eligibility questions in this section.

1) Is the other Medicare eligible adult applying either:
a. your spouse; or
b. someone with whom you are in a civil union partnership; and
c. someone with whom you have continuously resided for the past 12 months?

Applicant A ○ Yes ○ No

Applicant B ○ Yes ○ No

If both answered "yes", and purchase this policy, you will qualify for the household premium discount.

2) Or, does the other Medicare eligible adult already have Medicare supplement coverage with the same or another Aetna Company that also has available a household discount and is either:
a. your spouse; or
b. someone with whom you are in a civil union partnership; and
c. someone with whom you have continuously resided with for the past 12 months?

Applicant ○ Yes ○ No

If yes, please provide the following information:

Name: .....

Address: .....

.....

Policy Number: .....

Upon verification of eligibility, and approval of your application, you and the existing policyholder will qualify for the discount.

Applicant A Plan selected:

.....

Requested Medicare Supplement effective date: *mm/dd/yyyy*

.....

Modal premium:
$.....

Modal premium with discount:
$.....

Application fee*:
$.....

Total initial premium collected/draft:
$.....

Payment mode: ○ Annually ○ Quarterly ○ Semi-Annually ○ Monthly EFT (Electronic Funds Transfer)

Payment method
○ Check ○ EFT
○ List Bill billing file identifier _____

Initial premium:
○ Draft initial premium upon policy approval
○ Draft initial premium on policy effective date

Applicant B Plan selected:

.....

Requested Medicare Supplement effective date: *mm/dd/yyyy*

.....

Modal premium:
$.....

Modal premium with discount:
$.....

Application fee*:
$.....

Total initial premium collected/draft:
$.....

Payment mode: ○ Annually ○ Quarterly ○ Semi-Annually ○ Monthly EFT (Electronic Funds Transfer)

Payment method
○ Check ○ EFT
○ List Bill billing file identifier _____

Initial premium:
○ Draft initial premium upon policy approval
○ Draft initial premium on policy effective date

HOUSEHOLD PREMIUM DISCOUNT INFORMATION

In order to be eligible for the household discount under an American Continental Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by an Aetna Company Medicare Supplement policy. The Medicare eligible adult must be either: (a) your spouse; or (b) someone with whom you are in a domestic partnership; and (c) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rates will be 7 percent lower than the individual rates and will apply as long as both policies remain in force. Domestic Partners can be of the same or opposite gender (same sex only or opposite sex only proposals by insurers would fail under equal protection clauses of U.S. and Georgia constitution, in our opinion).

PAYMENT MODES
Each payment mode, other than annual and monthly electronic funds transfer, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates. The annual and monthly electronic funds transfer modes have the same and lowest total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You may change your payment mode, among the modes available, during the life of your policy.

3. Eligibility questions

Please answer all questions.

NOTE: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to question 2.

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.

To the best of your knowledge:	**Applicant:**	**A**	**B**
1. Did you turn age 65 in the last 6 months?		○Y ○N	○Y ○N
A. Did you enroll in Medicare Part B in the last 6 months?		○Y ○N	○Y ○N
B. If yes, what is the effective date? **Applicant A** effective date . / / **Applicant B** effective date . / /			
2. 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
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. **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
4. Do you have another Medicare Supplement policy inforce?		○Y ○N	○Y ○N
A. If so for **Applicant A**, with what company, and what plan do you have? Company . Plan . If so for **Applicant B**, with what company, and what plan do you have? Company . Plan .			
B. If so, do you intend to replace your current Medicare Supplement policy with this policy?		○Y ○N	○Y ○N
5. 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 for **Applicant A**, with what company, and what kind of policy? 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.) Start date . / / End date . / /			
A. If so for **Applicant B**, with what company, and what kind of policy? 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.) Start date . / / End date . / /			

4. Health questions

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

If the health questions are answered for an Open Enrollment or Guaranteed Issue application, the application cannot be processed and will be returned.

If any health questions are answered "yes" in Section 4, the applicant(s) will not qualify for this insurance with us.

Applicant:	A	B
1. Are you dependent on a wheelchair or any motorized mobility device?	○Y ○N	○Y ○N
2. Do any of the following apply to you?		
Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy	○Y ○N	○Y ○N
3. Within the last 10 years, at any time, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. congestive heart failure, unoperated aneurysm, defibrillator	○Y ○N	○Y ○N
B. leukemia, lymphoma, multiple myeloma, cirrhosis	○Y ○N	○Y ○N
C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy	○Y ○N	○Y ○N
D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease	○Y ○N	○Y ○N
E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	○Y ○N	○Y ○N
F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV)	○Y ○N	○Y ○N
4. Do you have diabetes?		
A. that requires use of insulin	○Y ○N	○Y ○N
B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage	○Y ○N	○Y ○N
C. with history of heart attack or stroke (at any time)	○Y ○N	○Y ○N
D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	○Y ○N	○Y ○N
5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. alcoholism, drug abuse	○Y ○N	○Y ○N
B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder	○Y ○N	○Y ○N
C. internal cancer, melanoma, Hodgkin's Disease	○Y ○N	○Y ○N
D. hepatitis, disorder of the pancreas	○Y ○N	○Y ○N
6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease	○Y ○N	○Y ○N
B. myasthenia gravis, systemic lupus or connective tissue disorder	○Y ○N	○Y ○N
C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	○Y ○N	○Y ○N
D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder	○Y ○N	○Y ○N
E. any lung or respiratory disorder and currently use tobacco products	○Y ○N	○Y ○N
7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, any surgery that has not been performed, or do you have any pending test results?	○Y ○N	○Y ○N
8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?	○Y ○N	○Y ○N
9. Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving injections?	○Y ○N	○Y ○N

Health questions *continued*

Systolic is the upper number and Diastolic is the bottom number of a blood pressure reading.

	Applicant:	A	B
10. Within the past 12 months, do any of the following apply to you?			
A. had a pacemaker implanted		○Y ○N	○Y ○N
B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer		○Y ○N	○Y ○N
C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer		○Y ○N	○Y ○N
D. had a seizure		○Y ○N	○Y ○N
11. Within the past 10 years, has your blood pressure reading been higher than 175 Systolic or higher than 100 Diastolic?		○Y ○N	○Y ○N

5. Applicant A health history

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

2. Within the past 5 years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

3. **Prescribed medications within the last 10 years**	**Reason for medications (diagnosis)**
.	.
.	.
.	.
.	.

Use an additional sheet of paper if needed for explanation.

Applicant B health history

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

2. Within the past 5 years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

3. **Prescribed medications within the last 10 years**	**Reason for medications (diagnosis)**
.	.
.	.
.	.
.	.

Use an additional sheet of paper if needed for explanation.

6. Applicant A physician information

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

Your primary physician Phone

Physician's office name

City State

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Have you seen any additional physicians other than those listed above in the past 24 months? ○ Y ○ N

Applicant B physician information

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

Your primary physician Phone

Physician's office name

City State

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Have you seen any additional physicians other than those listed above in the past 24 months? ○ Y ○ N

7. Important statements

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. 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.
6. 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).

8. Privacy notice

Although your application is our initial source of information, we may collect information, including health history and medical records, from persons other than you and we may conduct a telephone interview with you. American Continental Insurance Company, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

9. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our companies, or for the percentage of completed sales. Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

10. Applicant(s) agreement

I hereby apply to American Continental Insurance Company for a policy to be issued in reliance on my written answers to the questions on this application. I have read and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are true, complete and correctly recorded. I acknowledge that I have received an outline of coverage for the policy applied for and *A Guide to Health Insurance for People with Medicare*.

I understand that I will receive a copy of the signed application and that a copy is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that upon acceptance of the completed application, each applicant will receive a separate policy with a copy of this application attached.

I agree (1) this application and any policy issued will constitute the entire contract of insurance and the Company will not be bound in any way by any statements, promises or information made or given by or to any agent or other person at any time unless the same is in writing and submitted to the Company at its Home Office and made a part of such contract. Only a Company Officer can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing; and (2) this application shall not be approved until the first premium is paid, there has been no change in my health as stated in the application and a policy has been issued by the Company.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand that if any answers on this application are incorrect, incomplete or untrue, American Continental Insurance Company has the right to adjust my premium, reduce my benefits or rescind this policy.

Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as determined by a court of competent jurisdiction.

Applicant A signature Date signed

X .

Applicant B signature Date signed

X .

11. Applicant A account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 10 days greater than the policy's paid to date will draft a month in advance.

Name

Account owner name, if different than proposed insured's

Account owner relationship to proposed insured: ◯ Business owned by proposed insured ◯ Living trust ◯ Employer ◯ Power of Attorney ◯ Conservator/guardian ◯ Family member; specify

Financial institution name

◯ Checking ◯ Savings

Routing number

Account number

Draft date if different from effective date

Applicant B account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 10 days greater than the policy's paid to date will draft a month in advance.

Name

Account owner name, if different than proposed insured's

Account owner relationship to proposed insured: ◯ Business owned by proposed insured ◯ Living trust ◯ Employer ◯ Power of Attorney ◯ Conservator/guardian ◯ Family member; specify

Financial institution name

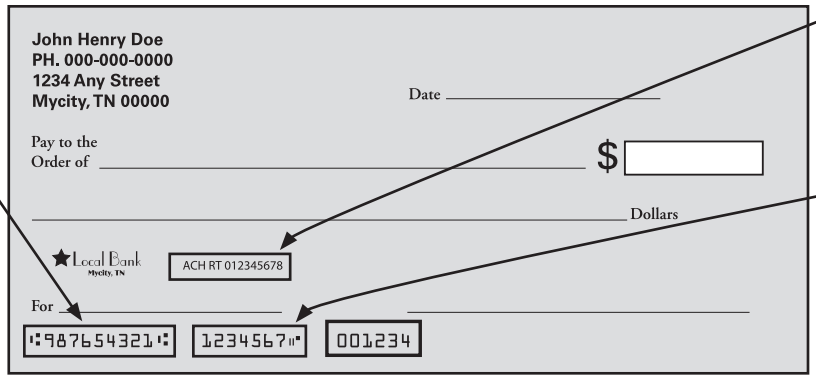
◯ Checking ◯ Savings

Routing number

Account number

Draft date if different from effective date

This is an example of a personal check. A business check may be different.



For all other checks, use the nine-character bank **routing number**, which appears between the ⑆ symbols, usually at the bottom left corner of the check.

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the ⑈ symbol at the bottom of the check and usually to the right of the bank routing number.

12. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner for **Applicant A** Date

X .....

Signature of account owner for **Applicant B** Date

X .....

13. Agent

All information **must** be completed.

Please list any other medical or health insurance policies sold to **Applicant A**.

1) List policies sold which are still in force

.....

.....

2) List policies sold in the past 5 years which are no longer in force

.....

.....

Please list any other medical or health insurance policies sold to **Applicant B**.

1) List policies sold which are still in force

.....

.....

2) List policies sold in the past 5 years which are no longer in force

.....

.....

I certify that:

1. I have accurately recorded the information supplied by the applicant(s).
2. The application was provided to the applicant(s) to review and the applicant(s) has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy(ies).
3. I have provided an outline of coverage for the policy(ies) applied for and *A Guide to Health Insurance for People with Medicare* to applicant(s) prior to completing the application.

Agent name *Printed* Writing number (agent or company)

....

The writing number reflects where commissions will be paid.

Agent signature State license ID number (for FL only)

X .....

Phone E-mail

....

14. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through American Continental Insurance Company (ACI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACI commission schedule.

Agent Information *Print*

Writing Agent		Percentage
.		. %
Secondary Agent	**Writing number**	**Percentage**
.	.	. %

Writing Agent Signature

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

X .....

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

American Continental Insurance Company *An Aetna Company*
800 Crescent Centre Dr., Suite 200, Franklin, TN 37067

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

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

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

STATEMENT TO APPLICANT BY PRODUCER: 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(s) (check one):

_____ Additional benefits
_____ No change in benefits, but lower premiums
_____ Fewer benefits and lower premiums
_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D
_____ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment
_____ Other (please specify) _____
_____

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate, may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

(3) If, you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

_____ _____
Signature of Agent Signature of Applicant

_____ Date: _____
Printed Name of Agent

_____
Address of Agent
Date: _____

WHITE COPY: Home Office with Completed Application – YELLOW COPY: Applicant

aetna®

American Continental Insurance Company
An Aetna Company

800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067

Health Information Authorization

from American Continental Insurance Company

- Print clearly and use blue or black ink.
- This is a HIPAA Compliant Authorization.

To Agent: Have applicant complete and sign home office copy to submit with application. Applicant keeps one copy.

Applicant declarations

Please read these statements carefully

I authorize the use and disclosure of health information about me as described herein.

Health Information to be Used or Disclosed: This Authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive; the past, present, or future payment for my health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; alcoholism and mental illness; and may be in electronic or paper form. It does not include information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: American Continental Insurance Company; its insurance support organizations; its affiliates and reinsurers.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: physicians; health professionals; hospitals; clinics; the Veterans Administration; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; consumer reporting agencies; insurance support organizations.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my application; determine premium amounts, adjudicate claims and to support the operations of our health plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization; and that a copy of it is as valid as the original; (2) this Authorization will be valid for 24 months from the date signed; (3) if I do not sign this Authorization, or revoke it by writing to American Continental Insurance Company at its Administrative Office, the Company may decline my application; and (4) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization (5) Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Primary applicant please fill in this information

Signature of applicant **X** .

Date .

Printed name of applicant **X**

City .

State .

Zip .