PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

For Seniors with Medicare Parts A and B

SECTION 1 – CHOICE OF COVERAGE

Please check the box for your choice of coverage:

- ☐ **Standard Plan A**
- ☐ **Standard Plan B**
- ☐ **Standard Plan C**
- ☐ **Standard Plan D**
- ☐ **Standard Plan F**
- ☐ **Standard High Deductible Plan F**
- ☐ **Standard Plan G**

SECTION 2 – APPLICATION INFORMATION

This complete original application will be returned to you, for your records, along with your policy, when you are enrolled.

Please copy the information from your Medicare card here

NAME OF BENEFICIARY (Applicant)	CLAIM NUMBER	SEX
____________	____________	____________
IS ENTITLED TO	EFFECTIVE DATE	
HOSPITAL INSURANCE	____________	
MEDICAL INSURANCE	____________	

Requested effective date, or end date of prior Medicare supplement, if replacing ____ / ____ / ________

Name (as it appears on your Medicare card) ____________________

Social Security Number ☐☐☐☐☐☐☐☐☐ Date of Birth ____________

Home Address, Apt. No., Suite No. ____________________

City ____________ County ____________ State ________ Zip ________

Home Telephone Number ____________________

Billing Address, (if different from home address) ____________________

City ____________ County ____________ State ________ Zip ________

Care of/Attention ____________________

SECTION 3 – BILLING INFORMATION

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ PAC (Checking Account Deduction Only)

Philadelphia American Life Use Only

Broker Number ____________________

H/S ☐ Yes ☐ No

Amount Received $ ____________________

Policy No. ____________ Effective Date ____________

Affix check here. Please make check or money order for premium payable to Philadelphia American Life Insurance Company.

No agency checks are accepted.

Applicant: Please return application to agent or to the address below:

Philadelphia American Life Insurance Company, Underwriting Department
P.O. Box 4884
Houston, Texas 77210-4884

SECTION 4 – HEALTH HISTORY

THIS SECTION MUST BE COMPLETED BY APPLICANT

IF APPLYING DURING THE OPEN ENROLLMENT PERIOD OR IF YOU ARE A GUARANTEED ISSUED ELIGIBLE PERSON, DO NOT COMPLETE THIS SECTION (Skip to Section 8)

If the answer to any of the following questions is "Yes", you are not eligible for coverage.
Check the box next to any conditions that apply to you.

	Yes	No
1. Are you currently confined, or has confinement been recommended, to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair for any daily activity?	☐	☐
2. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for a total of 2 weeks or longer?	☐	☐
3. Within the past 2 years, have you been advised to have surgery which has not yet been done?	☐	☐
4. Within the past 5 years, have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment, been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for the following conditions:		
a. Heart conditions including but not limited to heart attack, open heart surgery, placement of pacemaker, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, coronary artery disease, stroke?	☐	☐
b. Alzheimer's disease, Parkinson's disease, senile dementia, organic brain disorder, or other senility disorder?	☐	☐
c. Any respiratory condition including but not limited to Chronic Obstructive Pulmonary Disease (COPD), asthma, or emphysema (excluding allergies)?	☐	☐
d. Internal cancer, leukemia, Hodgkin's disease, insulin dependent diabetes, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), chronic kidney disease, kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, organ transplant (except cornea), amputation or joint replacement due to disease?	☐	☐

Applicant's Initials: ______________

SECTION 5 – HEIGHT AND WEIGHT

Does your weight exceed the maximum weight on the Maximum Weight tables below? ☐ Yes ☐ No

MAXIMUM WEIGHT TABLES

Male:

Height	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"
Weight (lb)	173	176	178	181	185	191	197	202	208	215	222	230	236	240	248	253	261	269

Female:

Height	4'10"	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"
Weight (lb)	153	156	159	162	165	168	178	180	183	187	192	196	203	208	220	229	235

SECTION 6 – TOBACCO USAGE

Have you used any form of tobacco within the past 5 years? ☐ Yes ☐ No

I acknowledge that misrepresentation of this information may render the policy null and void.

Date:____________ ____

Applicant's Signature

SECTION 7 – PREFERRED RATES (AVAILABLE FOR PLAN G ONLY)

Is the applicant taking any maintenance medications for the following conditions: Congestive Heart Failure, Coronary Artery Disease, Chronic Respiratory Condition, Pulmonary Disease, Parkinson's Disease, Insulin-Dependent Diabetes, Alzheimer's Disease or Dementia, Internal Cancer, and Kidney or Liver Disease."?
☐ Yes ☐ No

Available for Plan G only: Applicant can apply for the preferred rate class if the answer is "No" to all questions in Section 4, 5, 6, and 7.

SECTION 8 – GENERAL INFORMATION

ANSWER ALL QUESTIONS IN THIS SECTION

Are you eligible for Medicaid? ☐ Yes ☐ No

Do you have another Medicare supplement insurance policy, certificate, or coverage in force? ☐ Yes ☐ No

If so, with which company?______________________________________

If so, do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

Do you have any other health insurance policies or coverages that provide benefits similar to this Medicare supplement policy? ☐ Yes ☐ No

If so, with which company? ____________________ What kind of policy ________________

Do you have any other health insurance policies or coverages sold to you which are still in force? ☐ Yes ☐ No

Do you have any other health insurance policies or coverages sold to you in the past 5 years which are still in force? ☐Yes ☐ No

Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

If so, as a Specified Low-Income Medicare Beneficiary (SLMB)? ☐ Yes ☐ No

If so, as a Qualified Medicare Beneficiary (QMB)? ☐ Yes ☐ No

If so, for other Medicaid medical benefits? ☐ Yes ☐ No

SECTION 9 – CONDITIONS OF APPLICATION

Please read the following carefully.

1. I agree to submit the premium required for the plan requested with this application. Such premium will be returned to me if my application is rejected or if I decide to cancel the policy within the first thirty (30) days. If my application is accepted, the amount paid will be applied to the premium.
2. Philadelphia American will not reject my application if it is submitted during the six-month period beginning in the first month after I first enrolled in Medicare Part B. If my application is not received during the open enrollment period, Philadelphia American has the right to reject my application. If Philadelphia American rejects my application, I will be notified in writing and the premium submitted with this application will be refunded. I understand and agree that if Philadelphia American rejects my application, under no circumstances will any Philadelphia American benefits be payable. ***Cashing of my check by Philadelphia American does not constitute approval of my application.***
3. If my application is accepted, this application will become part of the agreement between Philadelphia American and myself.
4. The selling agent has no authority to promise me coverage or to modify Philadelphia American underwriting policy or terms of any Philadelphia American coverage.
5. I alone am responsible for reading and accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, **even information about my Medicare coverage**, is false, incomplete or omitted and that Philadelphia American may void all coverage from the original effective date of the policy for intentional material misstatements or omissions.

SECTION 10 – AUTHORIZATION AND AGREEMENTS

Notice to Applicant

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 more than one type of coverage in addition to your Medicare benefits.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. 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 policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.
5. 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).

Authorization To Obtain or Release Medical Information – You Are Entitled To A Copy of This Signed Authorization for Your Files If Requested. (Read all five paragraphs and sign below)

- I hereby authorize the U.S. Department of Health and Human Services (including the Health Care Financing Administration and any contractors or agents, including Medicare intermediaries), any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of Philadelphia American any and all records pertaining to claims payments or rejections, medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or a claim.
- I also authorize Philadelphia American, or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such a disclosure is necessary to allow the processing of any claim.
- This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Philadelphia American to process claims. A photocopy shall be valid.
- I understand and agree to the Replacement Notification, the Disclosure Statement (only for Medicare SELECT applicants), the Conditions of Application and the Authorization. I acknowledge receipt of the "Guide to Health Insurance for People with Medicare," and "Outline of Medicare Supplement Coverage and Premium Information" as required. I understand that receipt of money with this application does not create Philadelphia American coverage. Coverage will come into effect only if this application is approved by Philadelphia American.
- I, the applicant, acknowledge that I have read and understand this Application in its entirety and realize that any false statement or intentional material misrepresentation in the Application may result in loss of coverage under the policy.

Warning: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits

X ______________________________ Applicant's Signature

______________________________ Date of Signature

MEDICARE SUPPLEMENT PLAN REPLACEMENT WORKSHEET

Agents please complete if replacing other existing Medicare coverage

Insured

Name	SS#
Proposed Plan	

Old Plan

Company Name	
Expiration Date	Contract No.

Benefit Comparison

See reverse side for Philadelphia American benefits. Check benefits that apply.
Write in benefits not listed
.

	Old Plan	Philadelphia American Plan
Part A Deductible		
Part A Coinsurance		
Additional Hospital Days		
Skilled Nursing Facility Coinsurance		
Part B Deductible		
20% Part B Coinsurance		
50% Part B Coinsurance (Nervous and Mental)		
Part B Excess Charges at 100%		
Prescription Drugs		
Emergency Travel Benefits Outside the U.S.		
At-Home Recovery		
Preventive Medical Care		
10% or Greater Premium Savings		

Does this plan have benefits clearly and substantially better than those of the old plans? __________
If yes, explain below:

Agent Signature ____________________________ Agent No. __________________ Date _____________

OPTIONAL MONTHLY CHECKING ACCOUNT DEDUCTION AUTHORIZATION FOR SENIORS

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Philadelphia American Life Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize Philadelphia American to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Philadelphia American premiums. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no obligation whatsoever even though such dishonor results in forfeiture of insurance.

Please attach a blank check marked "VOID".

Insured		Social Security Number	
		Bank Name	
X	Date	**X**	Date

Authorized Signature(s) (as it/they appear in the financial institution's records; all authorized persons must sign)

AGENT WORKSHEET

Does Your Plan Cover	Standard Plan A	Standard Plan B	Standard Plan C
Part A Deductible		X	X
Part A Coinsurance	X	X	X
Additional Hospital Days (150-515)	X	X	X
Part B Deductible			X
20% Part B Coinsurance	X	X	X
50% Part B Coinsurance (Nervous and Mental)	X	X	X
Part B excess Charges at 100%			
Prescription Drugs			
Emergency Travel Benefits Outside the U.S.			X
At-Home Recovery			
Preventive Medical Care			

Does You Plan Cover	Standard Plan D	Standard & High Deductible Plan F	Standard Plan G
Part A Deductible	X	X	X
Part A Coinsurance	X	X	X
Additional Hospital Days (150-515)	X	X	X
Part B Deductible		X	
20% Part B Coinsurance	X	X	X
50% Part B Coinsurance (Nervous and Mental)	X	X	X
Part B Excess Charges at 100%		X	X*
Prescription Drugs			
Emergency Travel Benefits Outside the U.S.	X	X	X
At-Home Recovery	X		X
Preventive Medical Care			

* Part B Excess Charges at 80%

PRIORITY PROCESSING

COMPLETE THIS FORM TO ENROLL IN THE OPTIONAL MONTHLY CHECKING ACCOUNT DEDUCTION AUTHORIZATION FOR SENIORS.

INCLUDE A BLANK CHECK MARKED "VOID".

A DEPOSIT SLIP IS NOT ACCEPTABLE.

PHILADELPHIA AMERICAN LIFE
INSURANCE COMPANY OF THE MIDWEST

SENIOR SERVICES
TOLL-FREE NUMBER

Monday – Friday
8:00 a.m. to 5:00 p.m.

(877) 368-4691

FOR AGENT ONLY

Please list any other health insurance policies or coverages you have sold to the applicant which are still in force, and any other health insurance policies or coverages you have sold to the applicant in the past five years which are no longer in force. Please submit with the application, as required:

Date	Name of Policy	Name and Address of Insurance Company
From: Mo./Yr. ______	______	Name: ______
To: Mo./Yr. ______	______	Address: ______
	______	City/State: ______

(Attach additional sheets if necessary)

I have read and understand the application. I additionally certify that I have given the "Guide to Health Insurance for People with Medicare," and an outline of coverage and a disclosure statement for the policy applied for, and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

SIGNED AT ______

Agent's Signature   Date of Signature   (City and State)

______

Print Agent's Name   Agent No.

______

Street Address   Telephone No.

______

City   State   ZIP

Premium Amount $______

Send Policy To: ☐ Agent ☐ Insured

The I.D. Card will be sent to the agent or insured in a separate mailing.

SENIOR SERVICES TOLL-FREE NUMBER

Monday - Friday: 8:00 a.m. to 5:00 p.m. (Central Standard Time)

(877) 368-4691

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

PREMIUM RECEIPT

Date ___________________________ Amount ___________________________

Name____

Social Security Number ____

Account _____________________ Check Number _________________________

Policy Description ____

Received by ____

This is a receipt for cash received only. This receipt does not guarantee insurance coverage.