

**ADMIRAL LIFE INSURANCE COMPANY OF AMERICA**

Home Office: Phoenix, AZ 85010

Administration: P.O. Box 10862 Clearwater, Florida 33757-8862

**APPLICATION #:**

**APPLICANT** (Exactly as shown on your Medicare ID Card)

Last First MI

**Check the Medicare Supplement Plan You Prefer:**

- |  |  |
|--|--|
| <input type="checkbox"/> Standardized Plan A | <input type="checkbox"/> Standardized Plan E |
| <input type="checkbox"/> Standardized Plan B | <input type="checkbox"/> Standardized Plan F |
| <input type="checkbox"/> Standardized Plan C | <input type="checkbox"/> Standardized Plan G |
| <input type="checkbox"/> Standardized Plan D |  |

**RESIDENCE ADDRESS**

Street:

City:

State:

Zip Code:

**AGE**

**DATE OF BIRTH**

**SEX**

Month

Day

Year

Male

Female

**AREA CODE**

**TELEPHONE NUMBER**

**SOCIAL SECURITY NUMBER**

**MEDICARE INFORMATION**

Medicare Part A Effective Date: \_\_\_\_\_

Medicare Part B Effective Date: \_\_\_\_\_

Medicare Claim Number: \_\_\_\_\_

Effective Date:

Special Requests:

Mailing Preference:

Mail to Agent

Mail to Applicant

If not answered, policy will be mailed to Agent.

**UNDERWRITING RISK CLASSIFICATION QUESTION**

Have you used any form of tobacco in the past five years?

Yes

No

(You do not have to answer this question if you are applying during open enrollment or a guaranteed issue period.)

MODAL PREMIUM: \$ \_\_\_\_\_

POLICY FEE: \$

**20.00**

TOTAL INITIAL PREMIUM: \$ \_\_\_\_\_

**PLEASE SELECT THE METHOD OF PAYMENT YOU WANT**

Bank Draft\*

Annual

Semiannual

Quarterly

Monthly Bank Draft

\*Draft Preference:

Draft on Effective Date

Draft on Issue

If not answered, will draft on issue.

**PART I – HEALTH QUESTIONS**

**YOU ARE NOT REQUIRED TO ANSWER HEALTH QUESTIONS 1-13 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE FOUR FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION.**

**IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-12, YOU ARE NOT ELIGIBLE FOR COVERAGE.**

1. Are you bedridden or do you require the assistance of a wheelchair or motorized mobility aid?  Yes  No
2. Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence?  Yes  No
3. Are you currently confined to a hospital, nursing facility or have you been hospitalized two or more times in the past year?  Yes  No
4. Are you currently using the services of a home health care agency?  Yes  No
5. Has surgery, treatment, therapy, or tests been advised by a physician but not performed?  Yes  No
6. Within the past two years have you had an amputation caused by disease?  Yes  No
7. Do you have now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for any of the following conditions:
  - a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Alzheimer's Disease, Organic Brain Syndrome, Senile Dementia, or other senility disorder?  Yes  No

**PART I – HEALTH QUESTIONS CONTINUED**

- b. Diabetes that has ever required more than 50 units of insulin daily?  Yes  No
- c. Diabetes in addition to any of the following: diabetic retinopathy, Peripheral Vascular Disease, neuropathy, any heart condition (including high blood pressure) or kidney disease?  Yes  No
- d. Do you have Renal Failure or any Kidney Disease requiring dialysis?  Yes  No
- e. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary condition?  Yes  No
- f. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma?  Yes  No
- g. Congestive Heart Failure (CHF), or Peripheral Vascular Disease?  Yes  No
- h. Osteoporosis with fracture?  Yes  No
- 8. Within the past two years have you had a heart attack, a Stroke, or a Transient Ischemic Attack (TIA), heart or heart valve surgery, a cardiac pacemaker replaced or implanted, or been treated with a heart defibrillating device?  Yes  No
- 9. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse, Paget's Disease, Lupus, Rheumatoid Arthritis, or Disabling Arthritis?  Yes  No
- 10. Have you been advised to have a joint replacement?  Yes  No
- 11. Have you had an organ transplant or been advised to have an organ transplant?  Yes  No
- 12. Do you have now, or during the past five years have you received medical treatment, or been diagnosed by a physician as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection?  Yes  No
- 13. Do you take prescription medications? If yes, please list below all the prescription medications you are currently taking. Attach an additional sheet if necessary.  Yes  No

Prescription Medication Name	Frequency and Dosage	**Diagnosis/Condition

**ALL PRESCRIPTION MEDICATIONS CURRENTLY BEING TAKEN MUST BE LISTED.**

**\*\* IN THE DIAGNOSIS/CONDITION COLUMN, WATER PILL, WATER RETENTION, FLUID RETENTION OR BLOOD THINNER ARE NOT ACCEPTABLE. THE MEDICAL CONDITIONS OR DIAGNOSIS FOR THE MEDICATION MUST BE LISTED.**

**Primary Physician Information**

**Name:**

**Address:**

**Telephone:**

**PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)**

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement 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 our application. PLEASE ANSWER ALL QUESTIONS. PLEASE MARK YES OR NO WITH AN "X."

To the best of your knowledge:

1. (a) Did you turn age 65 in the last 6 months?  Yes  No
- (b) Did you enroll in Medicare Part B in the last 6 months?  Yes  No
- (c) If yes, what is the effective date? \_\_\_\_\_

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

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,**

- (a) Will Medicaid pay your premiums for this Medicare Supplement policy?  Yes  No
- (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?  Yes  No

3. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. If you are still covered under this plan leave "END" blank
- |  |             |             |
|--|-------------|-------------|
|  | START       | END         |
|  | ___/___/___ | ___/___/___ |

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?  Yes  No

If yes, what company \_\_\_\_\_

Company telephone number \_\_\_\_\_ Policy number \_\_\_\_\_

- (c) Was this your first time in this type of Medicare plan? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)?  Yes  No
- (d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan?  Yes  No

4. (a) Do you have another Medicare Supplement policy in force?  Yes  No

(b) If so, with which company: \_\_\_\_\_  
with which plan: \_\_\_\_\_  
and what paid-to-date do you have? \_\_\_\_\_

- (c) If so, do you intend to replace your current Medicare Supplement policy with this policy?  Yes  No

5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?  Yes  No

(a) If yes, with what company and what kind of policy? \_\_\_\_\_  
\_\_\_\_\_

Company telephone number \_\_\_\_\_ Policy number \_\_\_\_\_

- (b) What are your dates of coverage under the other policy? If you are still covered under this plan leave "END" blank
- |  |             |             |
|--|-------------|-------------|
|  | START       | END         |
|  | ___/___/___ | ___/___/___ |

## IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

- (1) You do not need more than one Medicare Supplement Insurance 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 Insurance Policy.
- (4) 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 reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of 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 reinstated, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- (6) 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).

## OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

**Open Enrollment:** You are eligible for Open Enrollment and will not need to answer Health Questions 1-13 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

**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:

- (a) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits; or (2) 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; or
- (b) 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; or
- (c) 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; or
- (d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, bankruptcy or other involuntary termination of coverage or enrollment under the policy, substantial violation of a material policy provision, or material misrepresentation; or
- (e) 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 the insured person terminates coverage within 12 months of enrollment; or
- (f) Upon first becoming eligible for benefits under Part B at age 65, enrolled in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment
- (g) Lost eligibility for health benefits under Medicaid.

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

## AUTHORIZATION AND CERTIFICATION

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 other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Admiral Life Insurance Company of America, or its reinsurers, any such information. I understand that I am authorizing Admiral Life Insurance Company of America to receive my health information, prescription drug usage history and my non-medical information. The released information received by Admiral Life Insurance Company of America 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 Admiral Life Insurance Company of America. 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 Admiral Life Insurance Company of America *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 Admiral Life Insurance Company of America in writing at their Medicare Supplement Administrative Office: P.O. Box 10860, Clearwater, Florida 33757-8860. I understand that such revocation will not have any effect on actions Admiral Life Insurance Company of America 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, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

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 unless and until the application has been accepted and approved by the Company, the full 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 makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.**

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: \_\_\_\_\_  
(City /State)

Dated: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_  
(Month/Day/Year)

**AGENT'S CERTIFICATION**

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, 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 policy you have sold to the Applicant that is still in force.

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is 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's Signature:**

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Agent's Printed Name:**

\_\_\_\_\_  
**Agent No.:**