

BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road, N.E., P.O. Box 105185, Atlanta, GA 30348-5146

APPLICATION FOR INSURANCE
PREFERRED UNDERWRITING CLASS

PLEASE PRINT

Agent/Producer Name:
Agent #:

Proposed Insured: Social Security No., Sex, Place (State) of Birth, Age, Born (Mo., Day, Yr.), Height & Weight (Ft., In., Lbs.), Residence Address (Street or Route & Box No.), City, County, State, Zip Code, Telephone Number, Best Time to Call (AM/PM), Proposed Insured E-mail Address, Mail Policy To (Insured/Agent)

PRINT-To whom should premium notices be sent? Same address as Proposed Insured, or:
Payor name: Phone number:
Complete Address:

SELECT THE COVERAGE YOU WANT BY CHECKING THE APPROPRIATE BOXES BELOW

MEDICARE SUPPLEMENT PLANS: A F High Deductible F G K

Open Enrollment:

- (a) Is the Proposed Insured eligible for coverage under the "Open Enrollment" period...?
(b) Is the Proposed Insured eligible for coverage under the 63-day "guarantee issue" period...?

REQUESTED EFFECTIVE DATE:

PREMIUM MODE:

- Annual (MBD x 12)
Semi-Annual (MBD x 6)
Quarterly (MBD x 3)
Monthly Direct (MBD + \$2.00)
Monthly Bank Draft\*
Monthly Credit Card\*
\*Requested Draft Date

BILLING TYPE:

- Individual Family\*
\*Complete Family Billing Form B 0129 FB/LB

MODAL PREMIUMS - choose one column:

Table with columns: with Household Discount, without Household Discount. Rows: Monthly Bank Draft Premium, 5% Household Discount, equals Monthly Bank or Credit Card Premium, Other Modes, Total Initial Premium Due.

\* If the Proposed Insured does not qualify for the Household Discount, the full modal premium will be required.

- Draft initial premium\*, Check/money order included, Charge credit card for initial premium.
\*\*Initial Draft Date

INSURANCE INFORMATION

- 1. (a) Medicare claim number
(b) Is the Proposed Insured covered under Medicare Part A?
(c) Is the Proposed Insured covered under Medicare Part B?
(d) Is the Proposed Insured covered under Social Security Disability?
2. If you lost or are losing other health insurance coverage...
(A) Did you turn age 65 in the last 6 months?
(B) Did you enroll in Medicare Part B in the last 6 months?
(C) If yes, what is the effective date?
(D) Are you covered for medical assistance through the state Medicaid program?
(E) If you had coverage from any Medicare plan other than original Medicare within the past 63 days...
(F) Do you have another Medicare supplement policy in force?
(G) Have you had coverage under any other health insurance within the past 63 days?

**IF THE ANSWER TO ANY PART OF QUESTION 3 THROUGH 7 IS "YES," COVERAGE IS NOT AVAILABLE. IF ELIGIBLE FOR OPEN ENROLLMENT OR 63-DAY (90 DAYS IN WY ONLY) GUARANTEE ISSUE, DO NOT ANSWER QUESTIONS 3 THROUGH 9.**

3. In the past 5 years, has the Proposed Insured had or been medically diagnosed with or treated for:
- (a) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? .....  Yes  No
- (b) any lipodosis, including Gaucher's or Tay-Sachs or Wolman's? .....  Yes  No
4. In the past year, has the Proposed Insured:
- (a) been confined to a hospital 2 or more times or to a nursing facility, or receiving home health care or assistance with normal activities of daily living, such as dressing, bathing, eating, transferring or toileting? .....  Yes  No
- (b) been confined to a wheelchair or require the use of a wheelchair or motorized mobility aid due to a medical condition or on the advice of a physician? .....  Yes  No
- (c) been medically advised to have surgery or treatment or hospital/nursing facility confinement and not done so? .....  Yes  No
- (d) had any heart or circulatory surgery? .....  Yes  No
5. In the last 3 years, has the Proposed Insured had, been medically diagnosed with, or treated for:
- (a) heart attack, stroke of any kind, congestive heart failure, or amputation due to disease? .....  Yes  No
- (b) cirrhosis, liver disease, or hepatitis (excluding Type A)? .....  Yes  No
6. In the past 5 years, has the Proposed Insured had, been medically diagnosed with, or treated for:
- (a) emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, or used supplemental oxygen? .....  Yes  No
- (b) internal cancer, leukemia, malignant melanoma, Hodgkin's disease, kidney/renal failure or insufficiency, chronic kidney disease, or been advised to have or had dialysis? .....  Yes  No
- (c) Alzheimer's disease, dementia, organic brain syndrome, schizophrenia or delusional or psychotic disorder, alcoholism or drug addiction, or diabetes requiring insulin? .....  Yes  No
- (d) Parkinson's or Huntington's disease, multiple sclerosis, muscular dystrophy, Lou Gehrig's disease (ALS), systemic lupus, or sickle cell anemia? .....  Yes  No
- (e) testing or surgery for the transplanting of any organ or tissue (excluding corneal transplants)? .....  Yes  No
7. Has the Proposed Insured used any tobacco products in the last 3 years? .....  Yes  No
8. List all prescription drugs the Proposed Insured is currently taking or has been medically advised to take:  
(If "None," so state; if additional space is needed attach separate page and have Proposed Insured sign and date.)

Medication	Amount	Condition for Which Prescribed	Currently Taking?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

9. Please provide complete name, address and telephone number of the Proposed Insured's primary care physician:
- Physician's name: \_\_\_\_\_ Telephone number \_\_\_\_\_
- Physician's address: \_\_\_\_\_

**HOUSEHOLD DISCOUNT\* INFORMATION—PLEASE ANSWER BOTH QUESTIONS 10 AND 11 IN THIS SECTION.**

10. The Proposed Insured has continuously resided with another person for the last 12 months and the other person is also applying for this coverage. ....  Yes  No  
If "yes" please complete the information regarding relationship to applicant below.
11. The Proposed Insured has continuously resided with another person for the last 12 months and the other person has an existing Medicare Supplement policy with Bankers Fidelity Life Insurance Company. ....  Yes  No  
If "yes" please complete the information regarding relationship to the Proposed Insured below.
12. Name: \_\_\_\_\_  
Relationship to Applicant: \_\_\_\_\_  
 Application Pending or Existing Policy Number: \_\_\_\_\_

\* If the Proposed Insured does not qualify for the Household Discount, the full modal premium will be required.

**Ins-Special, Inc**  
**7305 State Hwy 37 / PO Box 218**  
**Purdy, MO 65734**  
**service@inspecial.com**  
**800-789-0182**

**13. NOTICE TO THE PROPOSED INSURED:** (a) You do not need more than one Medicare supplement policy. (b) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. (c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. (d) 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 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 the suspension. (e) 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 the suspension. (f) 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).

**14.** I, the undersigned Applicant, hereby apply to Bankers Fidelity Life Insurance Company® for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, true. **I agree the policy shall not be effective unless it has actually been issued, received by the Owner and the first premium paid and honored upon first presentation, all during the Proposed Insured's lifetime and before any change in the Proposed Insured's health as stated herein.** I have received an outline of coverage and a "Guide To Health Insurance For People With Medicare."

**The undersigned Applicant and/or Proposed Insured and agent state that the Applicant and/or Proposed Insured have read or had read to him the completed application and that the Applicant and/or Proposed Insured realize that any false statement or material misrepresentation in the application may result in loss of coverage under the policy(ies), subject to the "Incontestability" and/or "Time Limit On Certain Defenses" provision of the policy.**

**CAUTION: If the answers on this application are materially incorrect or untrue, Bankers Fidelity Life Insurance Company® may have the right to deny benefits or contest your policy, subject to the "Time Limit On Certain Defenses" provision of the Policy.**

**WARNING: 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 may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.**

Dated at \_\_\_\_\_, on \_\_\_\_\_ X \_\_\_\_\_  
City and State Month, Day, Year Proposed Insured's signature. Please read item 14 before signing.

X \_\_\_\_\_ X \_\_\_\_\_  
Agent's signature Agent's number Applicant's signature, if not Proposed Insured

**Ins-Special, Inc**  
**7305 State Hwy 37 / PO Box 218**  
**Parry, MO 65734**  
**service@inspecial.com**  
**800-733-6102**

WRITING AGENT COMPLETE

Is any of this insurance being purchased to replace or change any existing insurance?  Yes  No  
**Complete Replacement Notice(s) as required.**

I have sold the following health insurance policies to the Proposed Insured which are still in force: \_\_\_\_\_

I have sold the following health insurance policies to the Proposed Insured within the past 5 years which are no longer in force: \_\_\_\_\_

I, the undersigned agent, certify that: (1) I have personally interviewed the Proposed Insured; (2) I have accurately recorded the information supplied by the Applicant and/or Proposed Insured; and (3) I have given the Applicant and/or Proposed Insured an outline of coverage for the policy applied for and a "Guide To Health Insurance For People With Medicare."

I certify that to the best of my knowledge and belief the Medicare Supplement coverage applied for herein does not duplicate coverage the Proposed Insured currently has in force.

Is the Proposed Insured related to you?  Yes  No If "Yes," explain relationship:  Self  \_\_\_\_\_  
If "Yes," the co-signature of an independent third party is required.

I certify that I have independently verified the Proposed Insureds identify as required by the USA Patriot Act (PL 107-56) by viewing or through a U.S. Federal or state government-issued photo I.D.:

<input type="checkbox"/> Drivers License	<input type="checkbox"/> Passport	<input type="checkbox"/> Government-issued I.D. card	<input type="checkbox"/> Other Photo I.D.
State _____ # _____	Type _____	Type _____	Type _____
DL# _____	# _____	# _____	# _____

Dated at \_\_\_\_\_, on \_\_\_\_\_, X \_\_\_\_\_  
City and State Month, Day, Year Agent's signature Agent's number

X \_\_\_\_\_  
Co-signature (if required)

**Ins-Special, Inc**  
**7505 State Hwy 37 / PO Box 218**  
**Parry, MO 65734**  
**[www.inspecial.com](http://www.inspecial.com)**  
**800-700-0102**



**AUTHORIZATION TO HONOR RECURRING DRAFTS/WITHDRAWALS/CHARGES MADE BY AND PAYABLE TO BANKERS FIDELITY LIFE INSURANCE COMPANY®, ATLANTA, GA**

I hereby authorize you to pay from and charge to my account listed below any draft, withdrawal or charge, including electronic transactions, made by and payable to Bankers Fidelity Life Insurance Company®, Atlanta, GA for the premiums due on my insurance policy, provided there are sufficient funds in said account to honor such draft, withdrawal or charge upon presentation. I agree that your rights in respect to each draft, withdrawal or charge shall be the same as if it were a check, withdrawal or charge made personally by me.

This authorization shall remain in effect until Bankers Fidelity Life Insurance Company® has received written notification from me revoking this authorization and in such manner as to afford reasonable opportunity to act upon it. I agree that if any draft, withdrawal or charge is dishonored or refused, you shall be under no liability whatsoever, even if such dishonor or refusal results in the forfeiture of insurance.

**SELECT A OR B**

**A.  CHECKING AUTHORIZATION     SAVINGS ACCOUNT AUTHORIZATION**

Name of Financial Institution:		Type of Financial Institution: <input type="checkbox"/> Bank <input type="checkbox"/> Credit Union
Routing/ABA Number:	Account Number:	<b>Attach a voided check if the account number is different than the account number on the initial premium. If the authorization is for a Savings Account, attach a deposit slip.</b>
Signature of Account Holder	Date	

**B.  CREDIT CARD AUTHORIZATION**

Type of Card: <input type="checkbox"/> Mastercard <input type="checkbox"/> Visa <input type="checkbox"/> Discover	Account Number:
Name of Card Holder as it appears on account	Expiration Date _____ / _____ Month                      Year
Signature of Card Holder	Date _____

B 0129 MBD/CC

(8-03)

**COMPLETE FOR FAMILY BILLING/LIST BILL**

Multiple policies can be paid on a single automatic draft from the same account or billed on a single billing notice. The policies can be on one person or multiple insureds, as long as they are billed on the same day. To set up Family Billing, we will need the following information:

**NOTE: Family Billing/List Bill must have the same Payor for all policies listed.**

Name of Payor:		Social Security Number
Policy # (if existing policy)	Name of Primary Insured	Premium Amount
<b>Total Premium</b>		<b>\$</b>

Signature of Payor \_\_\_\_\_

Date \_\_\_\_\_

B 0129 FB/LB

(2-11)

**Bankers Fidelity Life Insurance Company®**

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, Georgia 30348-5185

**PREMIUM RECEIPT**

Received from \_\_\_\_\_ the sum of \$ \_\_\_\_\_ being payment on account of an application for insurance to the Bankers Fidelity Life Insurance Company®, which application bears the same date as this receipt. This receipt is for: \_\_\_\_\_ policy. Proposed insured: \_\_\_\_\_

The insurance applied for shall not take effect until a policy issued on the basis of the above mentioned application shall have been delivered to the proposed insured, and the full first premium paid, all during the lifetime and before any change in the insurability of the proposed insured as stated in the application. Otherwise, there shall be no liability on the part of the Company except to refund this payment upon surrender of this receipt.

Date \_\_\_\_\_ Agent \_\_\_\_\_

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY.  
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.  
THIS RECEIPT IS NOT VALID IF INITIAL PREMIUM IS PAID BY CREDIT CARD.**

B 0068 PR

(2-11)

**BANKERS FIDELITY LIFE INSURANCE COMPANY®**  
 4370 Peachtree Road, NE, Atlanta, Georgia 30319

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION IN COMPLIANCE WITH HIPAA**

In order for Bankers Fidelity Life Insurance Company® (or its affiliates or reinsurers) to evaluate my application for insurance, or if a policy is issued, to evaluate contestability or eligibility for payment of claims benefits and for the continuation or replacement of the policy, I hereby authorize any and all medical practitioners, physicians, nurses, pharmacists, hospitals, clinics, long-term care facilities, medical or medically-related facilities, laboratories, insurance companies and insurance support organizations (i.e.: the MIB Group), records custodians or anyone else with knowledge of me or my health to release any and all records and information within your possession, custody or control to Bankers Fidelity Life Insurance Company or its authorized representative.

Information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released. Such records and information may include, but is not limited to, the following: alcohol and/or drug abuse treatment, psychiatric treatment (except psychotherapy notes), prescription drug information or STD or other communicable disease testing and treatment.

Bankers Fidelity Life Insurance Company cannot process an application for insurance without this signed Authorization. Furthermore, determination of eligibility for payment of claims benefits will be based upon information obtained in accordance with this authorization. Failure to authorize us to obtain information from all necessary providers may result in a delay of your claim due to lack of complete information.

**I UNDERSTAND:**

1. Health information about me provided to Bankers Fidelity Life Insurance Company is protected by federal privacy regulations and that Bankers Fidelity Life Insurance Company will only use and disclose such information as allowable by law. However, I also understand that, upon disclosure pursuant to this authorization to any person or organization that is not covered by the federal privacy regulations (i.e. an insurance regulatory or other government agency), the disclosed information may no longer be protected by those regulations.
2. I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon this authorization or to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to Bankers Fidelity Life Insurance Company at the address above. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment or business operations.
3. Bankers Fidelity may release information obtained through this Authorization to its reinsurers, the MIB or other insurance companies as allowable by law.
4. I am entitled to receive a copy of this authorization.
5. A photographic copy of this authorization is as valid as the original.
6. This authorization will expire 24 months from the date signed.

Dated at \_\_\_\_\_ on \_\_\_\_\_

_____ Patient's Signature	_____ Patient's Printed Name	_____ Patient's Date of Birth
_____ Patient's Resident Address	_____ Patient's Social Security Number	_____ Patient's Phone Number
_____ Personal Representative's Signature	_____ Representative's Printed Name	_____ Relationship to Patient*

\*Describe Personal Representative's authority or relationship to Patient. If Power of Attorney, must provide copy of POA papers.

B 0148 HIPAA

(2-11)

**NOTICE TO THE APPLICANT  
 PART ONE**

Federal law requires that notice of investigation be given to persons applying for insurance.

In making this application for insurance to Bankers Fidelity Life Insurance Company®, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of the investigation. None of the information collected concerning the sexual orientation of the Proposed Insured will be used to determine his or her eligibility for insurance.

**PART TWO**

Information regarding your insurability will be treated as confidential. Bankers Fidelity Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Bankers Fidelity Life Insurance Company or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.