

Open Enrollment and Guaranteed Issue Worksheet

If any of the following situations apply, applicant is in an open enrollment or guaranteed issue period: (Situations may vary by state and coverage may be limited. Please refer to the Underwriting Guide for more information.)

ELIGIBILITY FOR OPEN ENROLLMENT

Applicant is:

- at least 64 ½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

Note: Coverage cannot be effective until your Medicare coverage is effective.

ELIGIBILITY FOR GUARANTEED ISSUE

Evidence of eligibility is required for the following situations.



Applicant:

- is in the original Medicare plan, has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending
- is in the original Medicare plan, has a Medicare Select policy, and moves out of the Select plan's service area
- loses coverage due to their Medicare supplement insurance company's insolvency or at no fault of the applicant
- the applicant leaves their Medicare supplement plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Applicant was enrolled in a Medicare Advantage (MA) plan, and:

- the plan is leaving the Medicare program or stops service in the applicant's area, or the applicant moves out of the plan's service area (applicant must switch back to original Medicare)
- the applicant leaves the plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

- the applicant decided to switch to original Medicare within the first year of joining a MA plan when first eligible for Medicare Part A at age 65

Applicant has the right to buy any Medicare supplement plan that is sold in the applicant's state by any insurance company.

- after dropping their Medicare supplement policy to join a MA plan for the first time, has been on the MA plan less than one year and wants to switch back

Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available, buy any Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Acceptable Evidence of Eligibility:

- a. Copy of the applicant's MA plan's termination notice
- b. Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
- c. Signed statement that the applicant has requested to be disenrolled from his/her MA plan
- d. Certification of group coverage
- e. Copy of the termination letter from employer or group carrier
- f. Image of insurance ID card (ONLY allowed if your MA plan is being terminated)

**Gerber Life
Insurance Company**

Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan Applicant A _____

Applicant B _____

Before you begin: Please go to the Height and Weight Chart on the next page to determine your eligibility for coverage, unless you are in an open enrollment or guaranteed issue period.

	Steps	Example Rate displayed is used for calculation purposes only.	Applicant A	Applicant B
#1	Age Write in your age at the time of signing the application. ZIP Code Indicate your ZIP Code used to determine your rate.	65 51502		
#2	Premium Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.	\$128.52		
#3	Payment Options To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	\$128.52 monthly payment \$385.56 quarterly payment \$771.12 semiannual payment \$1,542.24 annual payment		

Ins-Special, Inc
7505 State Hwy 37 / PO Box 218
Purdy, MO 65734
service@insspecial.com
800-789-0182



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Height and Weight Chart

Eligibility

Find your height in the left-hand column and look across the row to find your weight. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time.

	Decline	Standard	Decline
Height	Weight	Weight	Weight
4' 2"	< 54	54 - 145	146 +
4' 3"	< 56	56 - 151	152 +
4' 4"	< 58	58 - 157	158 +
4' 5"	< 60	60 - 163	164 +
4' 6"	< 63	63 - 170	171 +
4' 7"	< 65	65 - 176	177 +
4' 8"	< 67	67 - 182	183 +
4' 9"	< 70	70 - 189	190 +
4' 10"	< 72	72 - 196	197 +
4' 11"	< 75	75 - 202	203 +
5' 0"	< 77	77 - 209	210 +
5' 1"	< 80	80 - 216	217 +
5' 2"	< 83	83 - 224	225 +
5' 3"	< 85	85 - 231	232 +
5' 4"	< 88	88 - 238	239 +
5' 5"	< 91	91 - 246	247 +
5' 6"	< 93	93 - 254	255 +
5' 7"	< 96	96 - 261	262 +
5' 8"	< 99	99 - 269	270 +
5' 9"	< 102	102 - 277	278 +
5' 10"	< 105	105 - 285	286 +
5' 11"	< 108	108 - 293	294 +
6' 0"	< 111	111 - 302	303 +
6' 1"	< 114	114 - 310	311 +
6' 2"	< 117	117 - 319	320 +
6' 3"	< 121	121 - 328	329 +
6' 4"	< 124	124 - 336	337 +
6' 5"	< 127	127 - 345	346 +
6' 6"	< 130	130 - 354	355 +
6' 7"	< 134	134 - 363	364 +
6' 8"	< 137	137 - 373	374 +
6' 9"	< 140	140 - 382	383 +
6' 10"	< 144	144 - 392	393 +
6' 11"	< 147	147 - 401	402 +
7' 0"	< 151	151 - 411	412 +
7' 1"	< 155	155 - 421	422 +
7' 2"	< 158	158 - 431	432 +
7' 3"	< 162	162 - 441	442 +
7' 4"	< 166	166 - 451	452 +

Medicare supplement insurance is underwritten by
Gerber Life Insurance Company

Administrative Office
 P.O. Box 2271
 Omaha, Nebraska 68103-2271

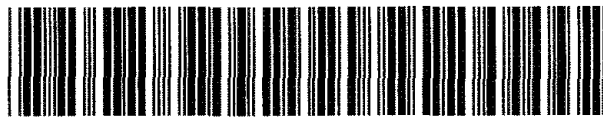


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B. Applicant Information (continued)

Applicant A				Applicant B				
Height	Ft	In	Weight	Lbs	Ft	In	Weight	Lbs
	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>



C. Medicare Information

Please reference your Medicare card to complete this section.

MEDICARE HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)	
NAME OF BENEFICIARY JANE DOE	
MEDICARE CLAIM NUMBER 000-00-0000-A	SEX FEMALE
IS ENTITLED TO HOSPITAL (PART A) MEDICAL (PART B)	EFFECTIVE DATE 07-01-2010 07-01-2010

Applicant A	Applicant B
Medicare Claim Number <input style="width: 90%;" type="text"/>	Medicare Claim Number <input style="width: 90%;" type="text"/>
Medicare Part A Effective Date <input style="width: 90%;" type="text"/> If you are not covered under Medicare Part A, what is your eligibility date <input style="width: 90%;" type="text"/>	Medicare Part A Effective Date <input style="width: 90%;" type="text"/> If you are not covered under Medicare Part A, what is your eligibility date <input style="width: 90%;" type="text"/>
Medicare Part B Effective Date <input style="width: 90%;" type="text"/> If you are not covered under Medicare Part B, indicate the date you plan to enroll <input style="width: 90%;" type="text"/>	Medicare Part B Effective Date <input style="width: 90%;" type="text"/> If you are not covered under Medicare Part B, indicate the date you plan to enroll <input style="width: 90%;" type="text"/>

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D. Previous or Existing Coverage Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. **Please include a copy of the notice from your prior insurer with your application.** PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge and Belief:		Applicant A	Applicant B
1. Are you covered for medical assistance through the state Medicaid program?.....		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(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," answer the following about this existing coverage:			
(a) Will Medicaid pay your premiums for this Medicare supplement policy?.....		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Please answer questions regarding another Medicare supplement or Select plan:

2. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
If "YES," answer the following about this existing coverage:		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Indicate planned termination or disenrollment date.....	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
(c) With what company, and what plan do you have?		

Applicant A	Applicant B
Name of Company	Name of Company
Plan	Plan

Please answer questions regarding Medicare plan coverage (other than Medicare supplement):

3. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO).....	Applicant A	Applicant B
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
If "YES," answer the following about this previous or existing coverage:		
(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.....	Applicant A START <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Applicant B START <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	END <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	END <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(c) Planned date of termination/disenrollment?.....	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
(d) Was this your first time in this type of Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(f) Did you drop a union group or employer health plan to enroll in this Medicare plan?..	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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**If you are applying during an open enrollment or guaranteed issue period:
SKIP SECTIONS F & G and GO TO SECTION H.**



F. Health Information

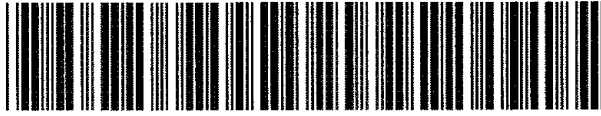
For all plans, answer questions 8-17.

(If "YES" is answered to any of the following questions 8-16, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
8. Are you currently confined to a wheelchair or any motorized mobility device?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
9. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility where you receive skilled nursing care, or receiving any occupational or physical therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing or any surgery that has not been performed?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
11. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alzheimer's Disease, dementia or any other cognitive disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Parkinson's Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Systemic Lupus or Myasthenia Gravis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
H. Chronic hepatitis or cirrhosis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
I. Osteoporosis with fractures?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Do you have diabetes with complications including retinopathy, neuropathy, peripheral vascular disease, any related heart disorder (Including hypertension/high blood pressure) or kidney disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Do you have an implanted cardiac defibrillator?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
14. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Cardiomyopathy, Congestive Heart Failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alcoholism or drug abuse?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Internal cancer, lymphoma or melanoma?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. A stroke or transient ischemic attack (TIA)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?...	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
15. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
16. Have you been hospital confined three or more times in the past two years for a same or similar condition?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
17. Have you used tobacco in any form in the past 12 months?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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G. Medication Information



If you are applying OUTSIDE of an open enrollment or guaranteed issue period, please list all over-the-counter or prescription medications you have taken in the past 24 months in the table below.

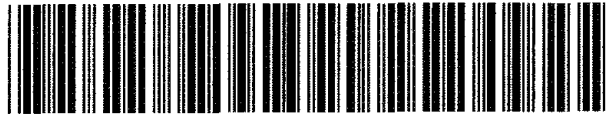
Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

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H. Agreement and Authorization

IMPORTANT STATEMENTS

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be 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.
- 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.
- 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 DISCLOSE PERSONAL INFORMATION TO GERBER LIFE INSURANCE COMPANY

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Gerber Life Insurance Company and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Gerber Life Insurance Company. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, Gerber Life Insurance Company, P.O. Box 2271, Omaha, NE 68103-2271. I realize that my right to revoke this authorization is limited to the extent that Gerber Life Insurance Company has taken action in reliance on the authorization or the law allows Gerber Life Insurance Company to contest the issuance of the policy or a claim under the policy.
- "Personal Information" means all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application 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 and a completed and signed application will become part of each applicant's policy.

I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Gerber Life Insurance Company.

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** and an Outline of Coverage.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement is guilty of insurance fraud.

Dated at _____, on _____/_____/_____, _____
 City State Month Day Year Applicant A's Signature

Dated at _____, on _____/_____/_____, _____
 City State Month Day Year Applicant B's Signature (if applying)

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METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN

Part I. Select Premium Payment Option

<p>Initial Premium (Select option #1 or #2) Initial premium amount (based on age at application date and includes one-time application fee in applicable states)....</p> <p>1. Paper Check (submit signed check with application).....</p> <p>2. Automated Bank Account Withdrawal.....</p> <p>Ongoing Premium Payments (Select option #1 or #2)</p> <p>1. I want my payments automatically withdrawn from my bank account every month on (Circle date).....</p> <p>2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing).....</p>	<p>Applicant A</p> <p>\$ _____</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p>1st or 15th</p> <p>every _____ months</p> <p>Insert 3, 6, or 12</p>	<p>Applicant B</p> <p>\$ _____</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p>1st or 15th</p> <p>every _____ months</p> <p>Insert 3, 6, or 12</p>
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Part II. Payor Information

<p>Complete the following if premium is NOT paid by applicant (includes spouse or joint-married account):</p> <p>1. Account Owner Name, if different than applicant's.....</p> <p>2. Account Owner Relationship to applicant:</p> <p style="padding-left: 100px;">Living Trust <input type="checkbox"/></p> <p style="padding-left: 100px;">Power of Attorney or legal guardian (documentation required) <input type="checkbox"/></p> <p style="padding-left: 100px;">Business owned by applicant or applicant's spouse <input type="checkbox"/></p>	<p>Applicant A</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p>Applicant B</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
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Part III. Account Information

Complete the following ONLY if Automated Bank Account Withdrawal is Chosen:
 This section is intended as authorization to debit your bank account.
 Complete bank account information below OR attach a copy of a voided check (Do NOT use a deposit slip)

<p>Can attach voided check here</p>	<p>Applicant A</p> <p>Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings</p> <p>Name of Financial Institution _____</p> <p>Routing Number (9 digits on lower left side of check) _____</p> <p>Account Number (Do NOT use Debit/Credit Card numbers) _____</p> <p>Name as Shown on Account _____</p>	<p>Applicant B <input type="checkbox"/> Same account as Applicant A</p> <p>Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings</p> <p>Name of Financial Institution _____</p> <p>Routing Number (9 digits on lower left side of check) _____</p> <p>Account Number (Do NOT use Debit/Credit Card numbers) _____</p> <p>Name as Shown on Account _____</p>
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- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.



Example:

Account Holder Name	Do NOT include the check # in the Routing or Account Number.
John Doe	Check #1234
Street Address	Date: _____
Town, City ZIP Code	
Pay to:	
Routing/Transfer Number	Account Number Dollars
Financial Institution Name & Address	
Signed By: _____	
⑆123456789⑆ 12345678 ⑆ 1234 ⑆	

IMPORTANT: When choosing to pay initial premium by Automated Bank Account Withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY. The first withdrawal date may be different from the monthly date selected for renewal premiums. I authorize Gerber Life Insurance Company to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account to Gerber Life Insurance Company any preauthorized electronic fund transfers. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

<p><input type="text"/></p> <p>Authorized Signature as Shown on Account</p> <p>_____</p> <p>Date</p>	<p><input type="text"/></p> <p>Authorized Signature as Shown on Account</p> <p>_____</p> <p>Date</p>
--	--

GERBER LIFE INSURANCE COMPANY

Administrative Office
P.O. Box 2271
Omaha, Nebraska 68103-2271

Initial Premiums Paid through Automated Bank Account Withdrawal

Medicare supplement applications may have their initial premiums automatically deducted from their checking or savings account through a specific Electronic Funds Transfer (EFT) process identified as Automated Bank Account Withdrawal. When they do, you may fax the application and required forms instead of mailing them.

Follow these easy steps to submit Med supp apps using Automated Bank Account Withdrawal for initial premiums:

Step 1 - Complete the Method of Payment form

For applicants wishing to pay electronically for either their **initial** or **renewal** premium(s), complete the entire Med supp *Method of Payment* form (T03_635), included in the application package:

Step 2 - Fax the following items included in the application package to the dedicated line for Automated Bank Account Withdrawal payments at 1-866-422-9139

1. Automated Bank Account Withdrawal fax transmittal cover sheet on the back of this form, T03_627
2. Med supp *Method of Payment* form, T03_635
3. Med supp application and other required forms

Tips for Submitting Initial Premiums through Automated Bank Account Withdrawal

- Do not send a signed check for the initial premium; clients could be charged twice
- Do not fax the forms more than once; additional charges could result
- If you fax the forms, do not mail them, too; processing errors occur and additional charges result

For producer use only. Not for use with the general public.

T03_627

T03_627

**Gerber Life
Insurance Company**

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Save this notice! It may be important to you in the future.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Gerber Life 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 new 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 Issuer, Agent, Broker or Other Representative:



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):

Applicant	Applicant B
<input type="checkbox"/> Additional benefits	<input type="checkbox"/> Additional benefits
<input type="checkbox"/> No change in benefits, but lower premiums	<input type="checkbox"/> No change in benefits, but lower premiums
<input type="checkbox"/> Fewer benefits and lower premiums	<input type="checkbox"/> Fewer benefits and lower premiums
<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D	<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D
<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment	<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Other (please specify)
_____	_____
_____	_____

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 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.

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

 _____ _____
Signature of Agent, Broker or Other Representative **Date**
 Gerber Life Insurance Company, P.O. Box 2271, Omaha, Nebraska 68103-2271

Applicant	Applicant B
Signature 	Signature 
Date	Date

T03_202



Ins-Special, Inc
7505 State Hwy 37 / PO Box 218
Purdy, MO 65734
service@insspecial.com
800-789-0182

T03_202

**Gerber Life
Insurance Company**

Documentation of Solicitation of Medicare Related Products

In accordance with Arkansas law, this form is to be completed for all Medicare Supplement, Medicare Advantage and Medicare Part D solicitations, where an application was completed. Place completed form in client file.

I certify that the solicitation of Medicare related product coverage for _____
(Client's Name)

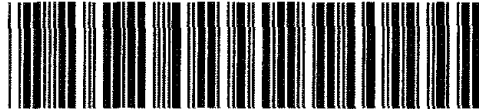
was solicited in the following manner.

- All replacement questions were asked and recorded on the application.
This application was was not a replacement.
 - If a replacement, I have reviewed the applicants current coverage and made a best effort to adequately inform the Medicare beneficiary of any substantial benefit differences between replaced and new coverages.
 - If a replacement, I have advised the Medicare beneficiary they have the right to contact the issuer of the policy that is being replaced for additional information
- The Medicare beneficiary signed the application
- A copy of the Outline of Coverage was left with the Medicare beneficiary



Agent's Name

Date



T03_214_AR

T03_214_AR

Complete and Retain in Applicant's File

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and client notifications on the following pages are to be given to the applicant(s) if applicable.

Replacement Notice

If replacing, both you and the applicant must sign the customer copy of the replacement notice.

Premium Receipt / Notice of Information Practices

**Gerber Life
Insurance Company**

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Save this notice! It may be important to you in the future.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Gerber Life 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 new 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 Issuer, Agent, Broker or Other Representative:

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):

Applicant	Applicant B
<input type="checkbox"/> Additional benefits	<input type="checkbox"/> Additional benefits
<input type="checkbox"/> No change in benefits, but lower premiums	<input type="checkbox"/> No change in benefits, but lower premiums
<input type="checkbox"/> Fewer benefits and lower premiums	<input type="checkbox"/> Fewer benefits and lower premiums
<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D	<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D
<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment	<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Other (please specify)
_____	_____
_____	_____

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

 _____ _____
Signature of Agent, Broker or Other Representative **Date**
 Gerber Life Insurance Company, P.O. Box 2271, Omaha, Nebraska 68103-2271

Applicant	Applicant B
Signature 	Signature 
Date	Date

T03_202



**Gerber Life
Insurance Company**

Premium Receipt

All premiums must be made payable to Gerber Life Insurance Company.

Do not make check payable to the agent or leave the payee blank.

Applicant A

Received from _____

this ____ day of _____, _____

an application for Form _____ Policy
and/or Riders _____ and

Check for _____ Dollars.

 Agent _____


Applicant B

Received from _____

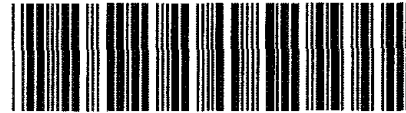
this ____ day of _____, _____

an application for Form _____ Policy
and/or Riders _____ and

Check for _____ Dollars.

 Agent _____

No insurance of any kind shall take effect until a policy is issued and delivered to the applicant, and the initial premium is paid, all during the life of the applicant. If no policy is issued, Gerber Life Insurance Company shall have no liability except to refund the initial premium to the applicant. This is a receipt of your application and initial premium.



Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: GERBER LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, P.O. BOX 2271, OMAHA, NE 68103-2271.

Provide the completed premium receipt, if applicable, and notice to the applicant.

T03_364

P.O. Box 2271
Omaha, NE 68103-2271



**Gerber Life
Insurance Company**

Call 1-877-617-5592
Fax 1-866-422-9139

Fax

Use to Transmit Applications with Initial Payment by Automated Bank Account Withdrawal 1-866-422-9139*

*Use this fax number only for applications and new-business documents. Applications faxed to any other number can cause processing delays.

Please complete the following information:

Total number of pages being faxed (including this cover sheet) _____

Producer Name	Producer Number or SSN
Phone Number	Fax Number

Comments _____

This communication and any attachments transmitted with it are confidential and are solely for the use of the addressee. It may contain material that is legally privileged, proprietary or subject to copyright belonging to Gerber Life Insurance Company and its affiliates, and it may be subject to protection under federal or state law. If you are not the intended recipient, you are notified that any use of this material is strictly prohibited. If you received this transmission in error, please contact the sender immediately by telephone, collect calls accepted, at the number shown above. We will arrange for you to return the original material to us via the U.S. Postal Service, and if requested, we will reimburse you for such expense.

T03_627