

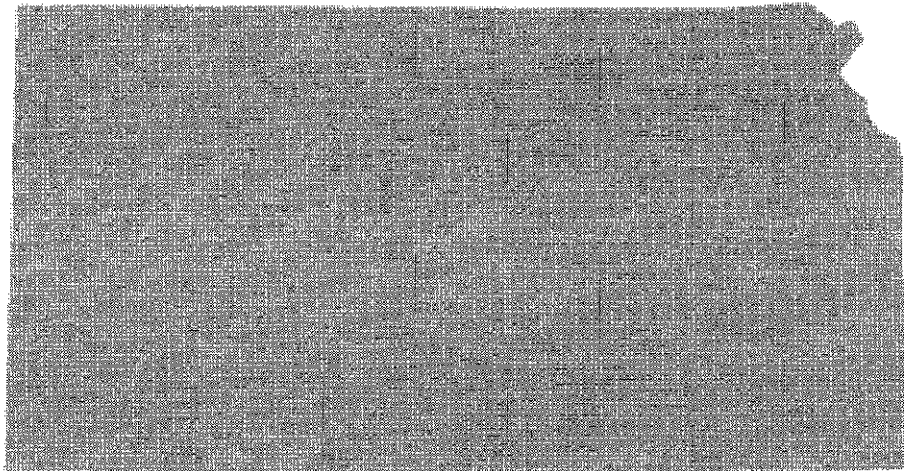
**HEARTLAND NATIONAL
LIFE INSURANCE COMPANY**

Medicare Supplement Administrative Office:
PO Box 10812, Clearwater, FL 33757-8812



**APPLICATION FOR
MEDICARE SUPPLEMENT INSURANCE**

KANSAS



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

HNAPP2010KS

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
 Home Office: Indianapolis, Indiana 46280
 Medicare Supplement Administrative Office: PO Box 10812, Clearwater, FL 33757-8812

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

| | |
|---|-----------------------------|
| Application #: | |
| Applicant (Exactly as shown on your Medicare ID Card) | Residence Address: |
| Last | Street |
| First MI | City |
| Indicate the Medicare Supplement Plan Applied for: | State Zip Code |
| Plan: _____ | Phone: (____) _____ - _____ |

| | |
|-------------------------------|------------------------------|
| SOCIAL SECURITY NUMBER | MEDICARE CLAIM NUMBER |
| | |

| AGE | DATE OF BIRTH | GENDER | HEIGHT | WEIGHT |
|-----|----------------|--|-----------------|-----------|
| | Month Day Year | <input type="checkbox"/> Male <input type="checkbox"/> Female | ____ ft ____ in | _____ lbs |

| PREMIUM PAYMENT | |
|---|---|
| Modal Premium: \$ _____ | Policy Fee: \$ _____ |
| Total Submitted Premium: \$ _____ | Requested Effective Date: _____ |
| or <input type="checkbox"/> Draft Initial Premium | |
| PLEASE SELECT THE METHOD OF PAYMENT YOU WANT | |
| <input type="checkbox"/> Annual | <input type="checkbox"/> Semiannual |
| <input type="checkbox"/> Quarterly | <input type="checkbox"/> Monthly Bank Draft |
| <input type="checkbox"/> I authorize Bank Draft payments. Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings | Amount to be drafted: \$ _____ |
| Bank Routing # (9 digits): _____ | Bank Account # (do not include check #): _____ |
| Bank Name: _____ | Select Bank Draft Day: (Cannot be more than 10 days beyond effective day) |
| Name(s) of Depositor(s): _____ | |
| Signature of Depositor: _____ | Date: _____ |
| Please include a voided check on a separate sheet of paper. | |

PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

1. Have you used tobacco in any form in the past 12 months? Yes No
2. Are you covered under Medicare Part A? Yes No
 If YES, what is your Part A effective date? ____/____/____
 If NO, what is your eligibility date? ____/____/____
3. Are you covered under Medicare Part B? Yes No
 If YES, what is your Part B effective date? ____/____/____
 If NO, what is your eligibility date? ____/____/____
4. Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility). Yes No

MEDICARE & INSURANCE INFORMATION (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. Did you turn age 65 in the last six months? Yes No
2. Did you enroll in Medicare Part B in the last six months? Yes No
 If "Yes", what is the effective date? ____/____/____
3. 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, answer a-b below.
- (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
4. (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 the other policy, leave "END" blank.) Start ____/____/____ End ____/____/____
 If YES, with which company _____
 Company telephone number: _____ Policy number: _____
- (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
- (c) Was this your first time in this type of Medicare plan? Yes No
- (d) Did you drop a Medicare Supplement plan to enroll in this Medicare plan? Yes No

MEDICARE & INSURANCE INFORMATION (Continued)

5. (a) Do you have another Medicare Supplement policy in force? Yes No
(b) If yes with which company: _____
with which plan: _____
what paid-to-date do you have? ____/____/____
Company telephone number: _____
(c) If yes, do you intend to replace your current Medicare Supplement policy with this policy? Yes No
6. 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 which company: _____
what kind of policy _____
what paid-to-date do you have? ____/____/____
Company telephone number: _____
(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, 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).

HEALTH QUESTIONS

Do not answer health questions 1-15 if you are in an open enrollment or guaranteed issue period. Please see page 6 for an explanation of open enrollment /guaranteed issue period information.

NOTICE TO APPLICANT: Please answer all of the following questions. Please verify the accuracy and completeness of the medical information on this application. Incomplete or false information on this application could jeopardize future claims. If you answer YES to any of the following questions 1 - 14, you are not eligible for coverage.

1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? Yes No
2. Have you been diagnosed with emphysema, chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disorders? Yes No
3. Have you been diagnosed with Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with fractures, cirrhosis or kidney disease requiring dialysis? Yes No
4. Have you been diagnosed with Alzheimer's disease, senile dementia, or any other cognitive disorder? Yes No
5. Have you been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)? Yes No
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), or kidney disease? If you do **not** have diabetes, this question should be answered "NO." Yes No
7. Do you have diabetes that has ever required more than 50 units of insulin daily? Yes No
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? Yes No
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? Yes No
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes No
11. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts? Yes No
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes No
13. Have you been hospital confined three or more times in the last two years? Yes No
14. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes No

HEALTH QUESTIONS Continued

15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If YES, please list the drug(s) below along with the date prescribed, dosage/frequency and diagnosis/medical condition for each medication. Attach a separate sheet if needed. Yes No

| | |
|---|--|
| Medication Name (copy off pharmacy label) | |
| Date Originally Prescribed | |
| Dosage and Frequency | |
| Diagnosis/ Medical Condition | |
| Medication Name (copy off pharmacy label) | |
| Date Originally Prescribed | |
| Dosage and Frequency | |
| Diagnosis/Medical Condition | |
| Medication Name (copy off pharmacy label) | |
| Date Originally Prescribed | |
| Dosage and Frequency | |
| Diagnosis/Medical Condition | |
| Medication Name (copy off pharmacy label) | |
| Date Originally Prescribed | |
| Dosage and Frequency | |
| Diagnosis/Medical Condition | |
| Medication Name (copy off pharmacy label) | |
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| Dosage and Frequency | |
| Diagnosis/Medical Condition | |
| Medication Name (copy off pharmacy label) | |
| Date Originally Prescribed | |
| Dosage and Frequency | |
| Diagnosis/Medical Condition | |
| Medication Name (copy off pharmacy label) | |
| Date Originally Prescribed | |
| Dosage and Frequency | |
| Diagnosis/Medical Condition | |

| |
|---|
| PRIMARY CARE PHYSICIAN INFORMATION |
| Physician's Name: _____ |
| Telephone Number: _____ |

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-15 on pages 4 and 5 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 as an employee, retiree, or dependent under an employee welfare benefit plan including federal or state provides health benefits that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such 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, 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 A of Medicare 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; or
- (g) Terminated coverage under a Medicare Supplement policy that covers outpatient prescription drugs and enrolled in Medicare Part D and submits evidence of such enrollment at the time of application; or
- (h) An individual who loses eligibility for health benefits under Title XIX of the Social Security Act (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.

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, 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 #1 Signature | Date | |
| Agent #1 Name (please print) | Agent # | Split % |
| Agent #2 Signature | Date | |
| Agent #2 Name (please print) | Agent # | Split % |

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 Medicare, that has any records or knowledge of me or my health to give Heartland National Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Heartland National Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Heartland National Life Insurance Company 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 Heartland National Life Insurance Company. 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 Heartland National Life Insurance Company *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 Heartland National Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 10812, Clearwater, Florida 33757-8812. I understand that such revocation will not have any effect on actions Heartland National Life Insurance Company 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, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

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 until my Medicare coverage is effective, the application has been accepted and approved by the Company, the 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 knowingly and with the intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto may be committing a fraudulent insurance act, which may be a crime as determined by a court of law.

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at:

_____ State

_____ Applicant's Signature

_____ Date

This section to be completed by an agent.

Signed at:

_____ State

_____ Writing Agent's Signature and Agent Number

_____ Date

Policy Mailing Preference:

Mail to Agent

Mail to Applicant

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

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: Indianapolis, Indiana 46280

Medicare Supplement Administrative Office: P. O. Box 10812 Clearwater, Florida 33757-8812

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 Heartland National 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 AGENT: 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 (check one):

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

If, you still wish to terminate your present policy 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 until you have received your new policy and are sure that you want to keep it.

Signature of Agent, Broker or Other Representative

Agent's Printed Name and Address

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature

Date

MSREPL2010

Return to Company.

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

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 Medicare, that has any records or knowledge of me or my health to give Heartland National Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Heartland National Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Heartland National Life Insurance Company 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.

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Signed at:

_____ State

_____ Applicant's Signature

_____ Date

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_____ Writing Agent's Signature and Agent Number

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Signature of Agent, Broker or Other Representative

Agent's Printed Name and Address

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature

Date

MSREPL2010

Leave with Applicant.

RECEIPT

All premium checks must be payable to: **Heartland National Life Insurance Company**.
Do not make checks payable to the agent or leave the Payee blank.
EFFECTIVE DATE will be the date of the application or the date of approval.

Received from _____
the sum of \$ _____ dollars for _____ months premium,
with application. If for any reason the application is not approved and the policy is not issued, this
premium is to be refunded. No liability is created or assumed by the Company, except for refund of this
premium, until the policy applied for has been issued.

Date Receipt and Outline of Coverage was prepared _____
By (Agent's Signature) _____