

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**  
**P.O. BOX 1154 • GLENVIEW • ILLINOIS 60025-1154 • 1-800-207-8050**

**APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE**

|  |     |               |     |        |            |              |          |      |
|--|-----|---------------|-----|--------|------------|--------------|----------|------|
| <b>APPLICANT</b>                                 |     | Last Name     |     |        | First Name |              |          | M.I. |
| Soc. Security #                                  | Age | Date of Birth | Sex | Height | Weight     | Phone Number |          |      |
|  |     | / /           |     | /      | lbs        | ( )          |          |      |
|  |     |               |     |        |            | Email        |          |      |
| <b>ADDRESS</b> Number & Street                   |     |               |     | City   |            | State        | Zip Code |      |
| <b>MAILING ADDRESS</b> (if different from above) |     |               |     | City   |            | State        | Zip Code |      |

**PLAN & PAYMENT INFORMATION**

|   |   |
|---|---|
| <p>1. Requested Effective Date or Replacement Date:<br/>_____</p> <p>2. I am applying for:<br/>Medicare Supplement Plan:<br/>Plan: <input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> N</p> | <p>3. <b>Premium Mode:</b><br/> <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual<br/> <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Bank Draft*</p> <p>Requested Draft Date _____</p> <p>Application Fee: \$ _____</p> <p>Total Modal Premium: \$ _____</p> <p>Premium Paid with Application: \$ _____</p> <p>* (1 month's premium required for bank draft)</p> |
|---|---|

**MEDICARE COVERAGE QUESTIONS**

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 that you had certain rights to buy such a policy, you may be guaranteed acceptance in one of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER QUESTIONS 4 THROUGH 9 COMPLETELY. Please mark Yes or No with an "X". To the best of your knowledge:

|  |   |
|--|---|
| <p>4. Are you covered or will you be covered under Medicare Parts A &amp; B? .....<br/>         (If the answer is "No", do not submit the application)<br/>         If yes, what is your Medicare claim number? (exactly as it appears on your Medicare Card) _____</p> <p>5. a. Did you turn age 65 in the last 6 months? .....<br/>         b. Did you enroll in Medicare Part B in the last 6 months or will you enroll in Medicare Part B in the next 6 months?....<br/>         If yes, what is/was the effective date? _____</p> <p>6. Are you covered for medical assistance through the state Medicaid program? (If the answer to 6a. or 6b. is "yes", do not submit the application.) 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.<br/>         If you answer yes,<br/>         a. Will Medicaid pay your premiums for this Medicare supplement policy? .....<br/>         b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....</p> <p>7. a. Do you have another Medicare supplement policy in force?.....<br/>         b. If so, with what company and what plan do you have? .....<br/>         c. If so, do you intend to replace your current Medicare supplement policy with this policy?.....<br/>         d. If yes, what is the Termination Date of your other Medicare Supplement Policy? _____</p> <p>8. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.<br/>         START ____/____/____ END ____/____/____<br/>         b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? .....<br/>         c. Was this your first time in this type of a Medicare plan? .....<br/>         d. Did you drop a Medicare supplement policy to enroll in the Medicare plan? .....<br/>         e. If your coverage has not ended please fill in a planned termination date? ____/____/____</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No<br/> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No<br/> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No<br/> <input type="checkbox"/> Yes <input type="checkbox"/> No<br/> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No<br/> <input type="checkbox"/> Yes <input type="checkbox"/> No<br/> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|---|

9. Have you had coverage under any other health insurance within the past 63 days?.....  Yes  No  
 (For example, Railroad Retirees, teachers plans, an employer union, group major medical or individual plan)  
 a. If so, with what company and what kind of policy?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 b. What are your dates of coverage under the other policy?  
 START \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ END \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 (If you are still covered under the other policy, leave the "END" blank.  
 c. If your coverage has not ended, please fill in a planned termination date? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**HEALTH QUESTIONS**

You do not have to answer questions 10 through 24 if you have enrolled in Medicare Part B within the past 6 months or are in a guarantee issue period. If not, and you answer "yes" to questions 10 through 23 below, you are not eligible for coverage

10. Are you currently hospitalized or confined to a nursing facility, or, are you bedridden or confined to a wheelchair? .....  Yes  No

11. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? .....  Yes  No

12. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, degenerative bone disease, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis? .....  Yes  No

13. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder? .....  Yes  No

14. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....  Yes  No

15. Do you have diabetes, and if so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, congestive heart failure, heart disease, or high blood pressure with three or more medications? .....  Yes  No

16. Do you have diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral)? .....  Yes  No

17. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation? .....  Yes  No

18. Within the past two years have you been treated, been advised to have treatment, been prescribed new medication or had changes in existing medication(s) for coronary or carotid artery disease, heart rhythm disorders including pacemakers or a defibrillator, a heart attack, congestive heart failure, or enlarged heart, stroke, transient ischemic attack (TIA), heart valve surgery, or peripheral vascular disease? .....  Yes  No

19. Within the past two years have you been treated for crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? .....  Yes  No

20. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts? .....  Yes  No

21. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? .....  Yes  No

22. Have you been hospital confined three or more times in the last two years? .....  Yes  No

23. Have you had an organ transplant or been advised by a physician to have an organ transplant? .....  Yes  No

24. Have you used any tobacco products in the past 12 months? .....  Yes  No

25. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? .....  Yes  No  
 If, "YES", please list the drug and the condition in the following table.

| Applicant (please attach a separate sheet if needed) | Medication Name (copy off pharmacy label) |
|--|---|
|  | Date Originally Prescribed                |
|  | Frequency and Dosage                      |
|  | Diagnosis/Condition                       |
|  | Medication Name (copy off pharmacy label) |
|  | Date Originally Prescribed                |
|  | Frequency and Dosage                      |
|  | Diagnosis/Condition                       |
|  | Medication Name (copy off pharmacy label) |
|  | Date Originally Prescribed                |
|  | Frequency and Dosage                      |
|  | Diagnosis/Condition                       |

**DISCLOSURE & AUTHORIZATION**

**DISCLOSURE:** 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 coverages. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. 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. 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 the 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).

**APPLICANT'S AUTHORIZATION & AGREEMENT:** I authorize United National Life Insurance Company of America (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my physical condition, other coverage and any other information needed to underwrite my application for insurance. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from MIB, Inc.. This Authorization includes all information about drugs, alcoholism, and mental illness. I agree that this Authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as the Company has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my agent or to the attention of the Underwriting Manager.

I understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by the Company in accordance with federal or state law. I also understand that my application for insurance can be declined if I choose not to sign this Authorization.

**ACKNOWLEDGEMENTS:** The Applicant represents and agrees as follows: 1) That the statements contained in the application concerning past and present health are complete. 2) Any coverage issued as a result of this application shall, together with this application, constitute a single and entire contract of insurance. 3) No agent or any other person is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Company's rights or requirements. 4) Any insurance issued as a result of the application will not take effect unless and until the full first premium is paid and the policy is delivered during such person's lifetime. 5) Provisions concerning exceptions, exclusions, limitations and renewal of the insurance plan which has been applied for, have been explained and are understood. 6) The applicant shall be owner of any insurance applied for. 7) The applicant acknowledges receipt of the Outline of Coverage, and has read the authorization and received copies of the "Notice to Applicant, Parts 1 and 2" describing the Medical Information Bureau and explaining the rights of the applicant under the Fair Credit Reporting Act.

**AGREEMENT:** I have read, or had read to me, the completed application. I hereby agree that: 1) all the statements and answers in this application are complete and true to the best of my knowledge and belief; and 2) **no insurance will be effective until my policy is issued.**

**Caution: If your answers on this application are incorrect or untrue, United National Life Insurance Company of America may deny benefits or rescind your policy.**

**We are required to give you this notice: Any person who, with the intent to defraud or knowledge that he is facilitating a fraud against the insurer, submits an application or files a claim containing false, incomplete, or deceptive statements of material fact may be guilty of insurance fraud.**

Applicant's Signature

City & State signed

Date

MAIL POLICY TO:  Agent  Insured

**AGENT'S REPORT:** List of health policies or certificates I have sold to the Applicant in the last 5 years which are either in force or no longer in force:

| NAME OF INSURER | POLICY TYPE |
|-----------------|-------------|
|                 |             |
|                 |             |
|                 |             |

**AGENT'S STATEMENT**

I certify: 1) I have accurately recorded the information supplied by the Applicant; 2) I have given an Outline of Coverage for the policy being applied for and the Medicare Supplement Buyer's Guide to the Applicant; 3) I  am or  am not aware the policy applied for will replace an existing health insurance policy; and 4) I have reviewed the current health coverage of the Applicant and have completed the chart above, as applicable. I find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.

Agent's Signature \_\_\_\_\_ Agent's Name (please print) \_\_\_\_\_ Agent Code \_\_\_\_\_

Agent's E-mail Address \_\_\_\_\_ (Agent signature not required if sold through the mail.)

TYPE OF SALE:  In Person  Telephone  On-line  Mail

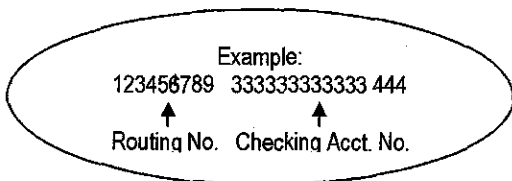
**MONTHLY PRE-AUTHORIZED PREMIUM PAYMENT PLAN**

Authorization to Honor Withdrawals to be drawn by United National Life Insurance Company of America.

TO \_\_\_\_\_  
Name of my Bank

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of United National Life Insurance Company of America, Glenview, Illinois, provided there are sufficient funds in my account to pay the same upon presentation.

Bank Routing #: \_\_\_\_\_ Checking Acct #: \_\_\_\_\_  
Account Type  Checking Account (Attach a Voided "Sample" check)  Savings Account (Attach a Voided "Sample" check if applicable, or a Deposit slip)



I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I further agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

Printed name of insured if different from premium payer \_\_\_\_\_ Premium payer's signature, as it appears on bank records \_\_\_\_\_

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

**AGENT NOTE: Please tear off this page and leave it with the Applicant.  
United National Life Insurance Company of America**

**NOTICE TO APPLICANT – PARTS 1 AND 2**

**Part 1: Fair Credit Reporting Act and Privacy Act Pre-Notification**

The application you completed for insurance with us, in most cases, gives us all the information we need. In certain cases, we may need more information.

If we need more information, we may get it by talking to other persons you know including, but not limited to, your agent or other insurance companies you have applied to. We may ask an independent "consumer reporting agency" to help us verify facts or get additional facts.

We may collect information covering your health, job and financial situation, as well as your character, general reputation and mode of living. We will not collect information relating to your sexual orientation.

The personal information we obtain about you is treated as confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary, as permitted by law, for the conduct of our business. But any information collected by a "consumer reporting agency" may be shared by the agency with others who use such information, but only to the extent which the Fair Credit Reporting Act permits.

You have a right of access, and right of correction, concerning recorded personal information obtained in our file. In order to exercise these rights, you must contact us in writing requesting access or correction. You have no access right to privileged information. If we used a "consumer reporting agency" you have the right to: (1) ask to talk with them and (2) ask them about their report. You may write us for the name and address of the agency. This paragraph is not intended as a complete description of your right of access and correction. If you would like a more complete description of our Insurance Information and Privacy Protection Practices, please write: United National Life Insurance Company of America, P.O. Box 1154, Glenview, IL 60025-1154.

**Part 2: Notification Regarding MIB, Inc.**

Information regarding your insurability will be treated as confidential. United National Life Insurance Company of America or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB Inc.'s file, you may contact them and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address to MIB Inc.'s office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (866) 692-6901, e-mail address [infoline@mib.com](mailto:infoline@mib.com). United National Life Insurance Company of America or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

**DESCRIPTION OF INFORMATION PRACTICES**

The description of Information Practices is being provided by United National Life Insurance Company of America in accordance with the requirements of the Insurance and Privacy Protection law in effect (if required) in your state of residence. Your application, in most instances, gives us all needed information. However, in some cases, we need to obtain more information by contacting other sources. This information, as well as other personal or privilege information collected, may in certain circumstances be disclosed to third parties without your authorization, but only to the extent permitted by law. You have the right of access and correct recorded personal information in our file (but not privileged information) by writing to us. This notice is not intended to be a complete description of your rights. For a complete description of our information practices, please write:

United National Life Insurance Company of America  
P.O. Box 1154  
Glenview, Illinois 60025-1154

**RECEIPT**

**DATE** \_\_\_\_\_

Received of \_\_\_\_\_ the sum of \$ \_\_\_\_\_  
and an application for insurance to United National Life Insurance Company of America. If for any reason the application is declined this payment will be refunded. No liability is created or assumed by the Company, except for refund of this payment, until the insurance applied for has been issued.

Agent's Signature \_\_\_\_\_

If you do not receive your policy/certificate within 60 days from the date of your application, please write to:

United National Life Insurance Company of America, P.O. Box 1154, Glenview, Illinois 60025-1154

**MAKE CHECK PAYABLE TO: UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**