pick the right plan for you

YES

Provided service:	Medicare pays:	Medicare supplement insurance† pays:			
		Plan A:	Plan F / High Deductible* Plan F:	Plan G:	Plan N:
Medicare Part A hospital coverage					
Medicare Part A deductible	With Medicare, you have a $1,600 deductible that must be paid before Medicare pays benefits	Nothing	$1,600	$1,600	$1,600
First 60 days of hospital confinement[1]	100% after deductible	Nothing	$1,600	$1,600	$1,600
Days 61-90 of hospital confinement[1]	All but $400 a day	$400 per day	$400 per day	$400 per day	$400 per day
Days 91-150 of hospital confinement[1] *(One-time benefit)*	All but $800 a day	$800 per day	$800 per day	$800 per day	$800 per day
Extended hospital coverage[1] *(Up to an additional 365 days in your lifetime)*	Nothing	100% Medicare-eligible expenses	100% Medicare-eligible expenses	100% Medicare-eligible expenses	100% Medicare-eligible expenses
Blood	All but first three pints	First three pints	First three pints	First three pints	First three pints
Hospice care[2]					
	All but limited coinsurance/copayments for outpatient drugs and inpatient respite care	Medicare coinsurance/ copayment	Medicare coinsurance/ copayment	Medicare coinsurance/ copayment	Medicare coinsurance/ copayment
Skilled nursing facility care[2]					
First 20 days	100% of Medicare-approved amounts	Nothing	Nothing	Nothing	Nothing
Days 21-100 of admission	All but $200 per day	Nothing	$200 per day	$200 per day	$200 per day

† These plans are available for those who were eligible for Medicare prior to 2020.

* Plan F also has a high deductible Plan F. The high deductible plan pays the same benefits as Plan F after the member has paid a $2,700 calendar year deductible. Benefits from a high deductible Plan F will not begin until out-of-pocket expenses exceed $2,700. These expenses include Medicare deductibles for Part A and Part B. If you are eligible for Medicare on, or after, January 1, 2020, you are not eligible for Plan F or High Deductible Plan F.

1 Does not include nursing home stays.

2 Must meet Medicare requirements for admission.

Hospital means a Hospital that is approved or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals. Premium amounts may vary plan and benefit selection.

Provided service:	Medicare pays:	Medicare supplement insurance pays:			
		Plan A:	Plan F / High Deductible* Plan F:	Plan G:	Plan N:
Medicare Part B outpatient medical coverage					
Medicare Part B deductible	With Medicare, you have a $226 deductible that must be paid before Medicare pays benefits	Nothing	The $226 Medicare Part B deductible	Nothing	Nothing
Medicare Part B co-insurance	80% of the approved charges after deductible	20% of Medicare approved charges after deductible	20% of Medicare approved charges	20% of Medicare approved charges after deductible	Remaining balance after you pay $20 copayment for office visits, $50 copay for emergency room visit**
Excess charges *(Charges above Medicare approved charges)*	Nothing	Nothing	Plan pays 100% of charges not covered by Medicare	Plan pays 100% of charges not covered by Medicare	Nothing
Benefit for blood	First three pints: $0 Additional pints: 80% coinsurance after you pay $226 deductible	First three pints: 100% Additional pints: 20% coinsurance after deductible	First three pints: 100% Additional pints: 20% coinsurance after deductible	First three pints: 100% Additional pints: 20% coinsurance after deductible	First three pints: 100% Additional pints: 20% coinsurance after deductible
Home health care[2]					
Medically necessary skilled care services and medical supplies	Medicare pays 100%	Nothing	Nothing	Nothing	Nothing
Durable medical equipment	80% coinsurance after you pay $226 Part B deductible	20% coinsurance of Medicare approved charges after deductible	The $226 Part B deductible then 20% coinsurance for Medicare approved charges	20% coinsurance of Medicare approved charges after deductible	20% coinsurance of Medicare approved charges after deductible
Additional benefit					
Emergency care received outside the U.S.	Medicare pays nothing	Nothing	You pay first $250 (per calendar year) then the plan pays 80% of remaining costs to Lifetime Max of $50,000	You pay first $250 (per calendar year) then the plan pays 80% of remaining costs to Lifetime Max of $50,000	You pay first $250 (per calendar year) then the plan pays 80% of remaining costs to Lifetime Max of $50,000

* Plan F also has a high deductible Plan F. The high deductible plans pay the same benefits as Plan F after the member has paid a $2,700 calendar year deductible. Benefits from a high deductible Plan F will not begin until out-of-pocket expenses exceed $2,700. These expenses include Medicare deductibles for Part A and Part B. If you are eligible for Medicare on, or after, January 1, 2020, you are not eligible for Plan F or High Deductible Plan F.

** Waived if admitted.

2 Must meet Medicare requirements for admission.

Application for Medicare Supplement Insurance

American Heritage Life Insurance Company
PO Box 95464, Cleveland, OH 44101
Toll-free telephone: (888) 966-2345 • www.Allstatehealth.com • NPSMedicareSuppApps@ngic.com •Fax: (888) 344-3232

☒ New Business ☐ Conversion ☐ Reinstatement

Section A. Applicant Information

First Name	Middle Name	Last Name	
Social Security Number	Date of Birth ____/____/____ (mm/dd/yyyy)	☐ Male ☐ Female	
Residence Address	City	State	Zip Code
Mailing Address (if different)	City	State	Zip Code
Telephone Number ☐ Home ☐ Mobile ☐ Work	Email Address		

I agree to receive my certificate and any other plan documents or correspondence electronically. I understand that I can withdraw consent at any time and may receive a paper copy at no additional cost: ☐ Yes ☒ No

There are no hardware or software requirements to access the documents. You can access your documents online on our website via browser or smart phone. You may withdraw this consent, obtain a paper copy at no additional cost and update this information at any time by contacting us at PO Box 2070, Milwaukee, WI 53201-2070 or 888-966-2345. If you answer "No" to this question, written communication will be provided in paper form.

Applicant's Height _____ft _____in Weight _____lbs

When last have you used tobacco in any form, or used nicotine products including a patch, gum, or electronic cigarettes?

_____/_____ (mm/yyyy) ☐ Never

Section B. Plan Information

Did you first become eligible for Medicare due to age, disability or end-stage renal disease prior to January 1, 2020? ☐ Yes ☐ No

Plan Applied For:

☐ Plan A ☐ Plan F* ☐ Plan High F* ☒ Plan G ☐ Plan N

*Plan F and Plan High F only available to applicants eligible for Medicare prior to 2020.

Have you lived with any of the following people for the past 12 months and still live with them currently? ☐ Yes ☐ No

- Legal Spouse
- Domestic or Civil Union Partnership
- 1 to 3 Other Adults Age 50 or Older

If "Yes", list the name of the household resident(s): _____

Do they have or are they currently applying for a Medicare Supplement policy with American Heritage Life Insurance Company? ☐ Yes ☐ No

If Yes, what is the policy number _____

Section C. Medicare and Insurance 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 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 your application.**

Answer all questions to the best of your knowledge. Mark "YES" or "NO" with an "X" to the questions below.

1. Did you enroll in Medicare Part B within the past 6 months? ☐ Yes ☐ No
2. Did you turn age 65 within the past 6 months? ☐ Yes ☐ No

Medicare Number	**Medicare Part A Effective Date**	**Medicare Part B Effective Date**
_____	____/____/____ (mm/dd/yyyy)	____/____/____ (mm/dd/yyyy)

3. Are you applying during a guaranteed issue period? (NOTE: If "Yes," please **attach proof of eligibility.**) ☐ Yes ☒ No

4. Do you have another Medicare Supplement or Medicare Select insurance policy in force? ☐ Yes ☐ No
   If yes:
   (a) Name of Company _____ Plan____ Effective Date____/____/____ (mm/dd/yyyy)
   (b) Do you intend to replace your current Medicare Supplement policy with this policy? (If yes, complete the Replacement Notice.) ☐ Yes ☐ No
   (c) Indicate termination date ____/____/____ (mm/dd/yyyy)

5. 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:
   If you are still covered under this plan, leave "END" blank.
   Start____/____/____ (mm/dd/yyyy) End ____/____/____ (mm/dd/yyyy)
   (a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? (If yes, complete the Replacement Notice.) ☐ Yes ☐ No
   (b) Planned date of termination____/____/____ (mm/dd/yyyy)
   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   (d) Did you drop a Medicare Supplement or Medicare Select policy to enroll in this plan? ☐ Yes ☐ No

6. Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union, or individual health plan) ☐ Yes ☐ No
   If yes:
   (a) Name of company and type of policy _____
   (b) Start date____/____/____ (mm/dd/yyyy) End date ____/____/____ (mm/dd/yyyy)

7. Are you covered for medical assistance through the state Medicaid program? (Note to applicant: If you are participating in a "Spend-Down Program" and have not yet met your "Share of Cost," please answer "No" to this question.) ☐ Yes ☐ No
   (a) If yes, will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
   (b) If yes, do you receive any benefits from Medicaid **other than** payment toward your Medicare Part B premium? ☐ Yes ☐ No

8. Have you received a copy of the **Guide to Health Insurance for People with Medicare,** the **Outline of Coverage,** and the **Notice of Information Practices?** ☐ Yes ☐ No

Section D. Health Information

For applicants applying as an Open Enrollee or under Guarantee Issue rights, skip section D.

The information I provided on this enrollment form is complete, true and accurate to the best of my knowledge and belief. I realize that any incomplete, false, or inaccurate statement or material misrepresentation in the enrollment form may result in cancellation of my coverage, a change in my premium, or a rescission of my coverage.

Signature of Applicant: _____ **Date:** _____ _____ _____ **(mm/dd/yyyy)**

For underwriting purposes provide the name and address of your primary care physician

Name: _____

Address: _____

Please read through each question carefully and indicate any of the conditions that apply with a check mark in the box. If any of the answers to questions 1-8 below are "Yes" coverage cannot be issued.

1. Have you been recommended or scheduled for testing (excluding routine), treatment, follow-up, or surgery that has not been completed? ☐ Yes ☐ No
2. Are you currently hospitalized, confined to a bed, receiving dialysis treatment, receiving services from an Assisted Living Facility, Nursing Home, or dependent on a wheelchair or mobilized device? ☐ Yes ☐ No
3. In the last 12 months have you received Physical, Occupation, or Speech Therapy? ☐ Yes ☐ No
4. Have you been hospitalized or used an emergency room for treatment 2 or more times in the past 24 months? ☐ Yes ☐ No
5. If you have you been diagnosed or treated for diabetes (answer no if you have not been diagnosed or treated for diabetes) ☐ Yes ☐ No
   - Are you currently prescribed 3 or more medications to control High Blood Pressure?
   - Have you been treated for any diabetic complications including nephropathy, retinopathy, peripheral vascular disease, stroke, neuropathy, or heart disease?

6. Within the past 2 years have you been diagnosed, treated, evaluated, or prescribed medication for? ☐ Yes ☐ No

Cancer

- ☐ Hodgkin's Disease
- ☐ Internal Cancer
- ☐ Leukemia, Myeloma or Lymphoma
- ☐ Melanoma

Cardiovascular

- ☐ Chronic Atrial Fibrillation
- ☐ Chest Pain (Angina)
- ☐ Coronary Artery Disease, Angioplasty, Stent, or Bypass
- ☐ Heart Attack/Acute MI

Circulatory

- ☐ Aneurysm
- ☐ Blood/clotting disorder (excluding mild anemia)
- ☐ Deep Venous Thrombosis
- ☐ Embolus
- ☐ Peripheral Vascular Disease
- ☐ Transient Ischemic Attack
- ☐ Stroke

Neurological

- ☐ Muscular Dystrophy
- ☐ Multiple Sclerosis
- ☐ Transverse Myelitis

Other

- ☐ Adrenal gland disorders
- ☐ Chronic Hepatitis or liver cirrhosis
- ☐ Cushing Syndrome/Disease
- ☐ Joint Replacement Surgery that has not been completed
- ☐ Osteoporosis with fractures
- ☐ Amputation due to disease
- ☐ Chronic Pancreatitis
- ☐ Enzyme disorders
- ☐ Nephritis or Glomerulonephritis
- ☐ Pituitary disease or disorder

☐ Pulmonary disease (excluding asthma)
☐ Required use of a Cardiac Pacemaker or Defibrillator
☐ Spinal Stenosis
☐ Renal Artery Stenosis including Stent/Angioplasty
☐ Oxygen or Nebulizer use
☐ Substance Abuse (including more than 12 consecutive months of opioid usage)

7. Within the past 12 months have you been recommended for surgery or are you receiving any infusions or injections for treatment of: ☐Yes ☐No

☐ Arthritis of any kind
☐ Plaque Psoriasis
☐ Crohn's Disease
☐ Ulcerative Colitis

8. Within the past 10 years have you been diagnosed, treated, evaluated, or prescribed medication for? ☐Yes ☐No

Cardiovascular

☐ Cardiomyopathy
☐ Congestive Heart Failure
☐ Enlarged Heart
☐ Heart Valve Disease or Regurgitation

Neurological

☐ ALS (Amyotrophic Lateral Sclerosis)
☐ Alzheimer's Disease
☐ Dementia
☐ Parkinson's Disease

Autoimmune Disorder

☐ AIDS, ARC, or HIV infection
☐ Myasthenia Gravis
☐ Systemic Lupus
☐ Systemic Scleroderma

Other

☐ Chronic Obstructive Pulmonary Disease
☐ Cirrhosis
☐ Emphysema
☐ Organ, Bone Marrow, Tissue, or Stem Cell Transplant
☐ Renal Failure or End Stage Renal Failure
☐ Schizophrenia

If questions 1-8 were answered "No" please complete question 9. If question 9 is answered "Yes", preferred II rating is not available.

9. Within the last 5 years has medication been prescribed or recommended for the following: ☐Yes ☐No

a. Depression

10. Please list any medications that have been prescribed in the past 18 months for you; Include pills, creams, injections, liquids, inhalers, pumps, etc.

Medication	Reason taken	Dose	Frequency	Still taking?
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

Section F. Agent Statement

Type of Sale: ☐ Telephone ☐ In Person ☐ Internet ☐ Mail ☐ Other _____

Send Policy to ☐ Agent ☒ Applicant

Yes	No	
☐	☐	Did anyone assist the proposed insured in completing the application or answering the application questions?

Name _____

Relationship to the Applicant _____

Type of assistance provided _____

☑	☐	1. Did you review the Application for correctness and any omissions?
☑	☐	2. Did the Applicant review the Application for correctness and any omissions?
☐	☒	3. Are you related to the Applicant?

If Yes, provide relationship: _____

Listed below are all other health insurance policies I have (a) sold to the Applicant which are still in force; and (b) sold to the Applicant in the last 5 years which are no longer in force.

Company	Type of Policy	Effective Date	In Force
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

I certify: 1) I have accurately recorded the information supplied by the Applicant; 2) I have given the Applicant an **Outline of Coverage** for the policy being applied for, the **Guide to Health Insurance for People on Medicare,** and the **Notice of Information Practices**; and 3) 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 Signature: Mark Sheffield Date: _____ (mm/dd/yyyy)

Agent Name: Mark Sheffield Agent ID: 276224

Comments on medical conditions or medications-

Section E. Disclosure, Acknowledgements, and Agreement

Disclosure:

1. You do not need more than one Medicare Supplement 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 policy.
4. 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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the 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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. 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).

Acknowledgments and Agreement:

I wish to apply for Medicare Supplement insurance coverage. 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."

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this application. To the best of my knowledge and belief they are true and complete. I understand the Company may conduct a telephone interview with me regarding the answers. I understand and agree the policy applied for will not take effect until issued by the Company, and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the coverage.

Caution: If your answers on this application are incorrect or untrue, the Company has the right to deny benefits or rescind your coverage.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicant's Signature: _____

Signed at (City and State): _____ SC **Date:** _____ _____ **(mm/dd/yyyy)**

Billing Authorization

Please read the following carefully.

The accountholder of the method of payment provided during this enrollment process authorizes and requests the Insurer, or its designee, to initiate automatic payments against such indicated payment method for the payment of premiums and other indicated monthly dues included in the plan(s) being purchased during this enrollment process. Accountholder agrees that the electronic payment authorization for such automatic payments may be terminated by providing written notice to the Insurer. If the payment dates fall on a weekend or holiday, I understand that the payments may be executed on the previous business day. I understand that if I choose a draft date of the 29th, 30th or 31st of the month we may choose to change your payment to be executed on the 28th of each month. For Automated Clearing House (ACH) debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that the Insurer may at its discretion attempt to process the charge again. I certify that I am an authorized user of this method of payment and will not dispute the scheduled transactions; provided the transactions correspond to the terms indicated in this authorization form.

Signature of Primary Insured _____ Date _____

Allstate
HEALTH SOLUTIONS

Billing Information

Application Fee: $ Initial Premium: $_____ Total Amount Submitted: $	Requested Policy Effective Date ____/____/____(mm/dd/yyyy)	Draft Initial Premium on ____/____/____(mm/dd/yyyy)

Note: Recurring draft date is the same day as the first effective date of the policy. If this day does not exist in a month, payment will be drafted on the next business day.

Select policy premium payment option (check only one):

1. Bank Draft
   - ➔ Select Account Type: ☑ Checking ☐ Savings
   - ➔ Select frequency: ☑ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual
   - ➔ To begin withdrawals:

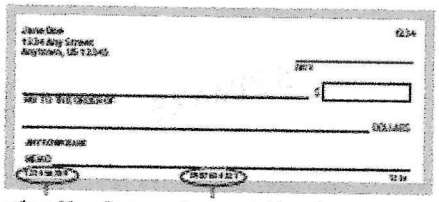
     Name on Account:_____

     Bank name:_____

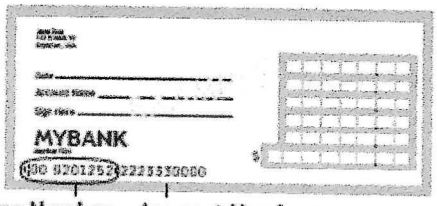
     Routing number: _ _ _ _ _ _ _ _ _

     Account number:_____

For paper application only: If paying premium by Bank Draft, please include a voided check. The first draft will occur on the date your application is approved by NHIC (unless specified otherwise). All Checks will be processed as EFT (Electronic Funds Transfer) from your bank.



Routing Number *9 digits* Account Number



Routing Number *9 digits* Account Number

2. Direct Bill (If paying by Direct Bill the first premium is required at time of submission)
   - ➔ Select frequency: ☐ Quarterly ☐ Semi-Annual ☐ Annual
   - ➔ If billing address is different than home address, please enter here:

Billing Address:

Street:_____

City: _____ State: _____ Zip code: _____

Allstate.
HEALTH SOLUTIONS

Medicare Supplement Activity Tracker Discount Authorization Form

Please fill out the following fields:

Applicant name: _____

Applicant phone number: _____

Applicant email address: _____
(An email address is required to participate in the Activity Tracker Discount program. By supplying your email address, you are agreeing to receive email correspondence about the Activity Tracker Discount program.)

Selling agent name: Mark Sheffield

Selling agent phone number: 910 232 4964

☐ Yes, I acknowledge I own an activity tracker or wearable device, and I am willing to share my fitness data.

☐ No, I do not want to participate and share my fitness data.

Authorize and Agree:

☐ By selecting this box, I acknowledge that I own an activity tracker or wearable device. I agree to register my activity tracker device within 30 days and share my activity data with Allstate Health Solutions insurance. I understand that if I do not register my device, my Activity Tracker Discount will be removed and my Medicare Supplement Insurance premium will be adjusted.

☐ By selecting this box, I agree to receive email correspondence from Allstate Health Solutions about the Activity Tracker program at the email address supplied above.

Applicant signature: _____

Date: _____

Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider that has provided services, treatment or payment to me, or on my behalf, within the past 10 years ("My Providers"), or consumer reporting agency, to disclose my entire medical record and any other protected health information concerning me to American Heritage Life Insurance Company ("AHLIC") and its agents, employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes and excludes information related to genetic tests or genetic services (except to pay a claim related to such tests or services).

In addition I authorize MIB, Inc., and any MIB member insurer, to provide any medical or personal information that it has about me toAHLIC, its reinsurer or any MIB-authorized third-party administrator performing underwriting services on AHLIC's behalf. I also authorize AHLIC, its reinsurer or authorized third-party administrator, to make a brief report of my personal health information to MIB, Inc.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that AHLIC may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; **2)** obtain reinsurance; **3)** administer claims and determine or fulfill their responsibility for coverage and provision of benefits; **4)** administer coverage; and **5)** conduct other legally permissible activities that relate to any coverage I have or have applied for with AHLIC.

For a period of 120 days from the date of this Authorization I authorize my AHLIC Producer to receive certain protected health information about me that is related to an adverse underwriting decision or counteroffer for alternative coverage made during the underwriting of my application.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to: **AHLIC at 1776 American Heritage Life Drive, Jacksonville, Florida 32224 Attention: Privacy Officer.** I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that AHLIC has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, AHLIC may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

Name of Applicant (please print)	Signature of Applicant or Personal Representative
Date of Birth	Date

Description of Personal Representative's Authority or Relationship to Applicant (if applicable)

(Return to Company)

AMERICAN HERTIAGE LIFE INSURANCE COMPANY

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

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Medicare Supplement Administrative Office: 1776 American Heritage Life Drive, Jacksonville, Florida 32224

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 American Heritage 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.

Mark Sheffield MARKSheffield MRKShef@yahoo.com

Signature of Agent, Broker or Other Representative Agent's Printed Name and Address

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

AY

_____ _____

Applicant's Signature Date

Return to Company

AHLIC NRN-2022

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Definition of Eligible Person for Guaranteed Issue

The following are definitions of the categories of individuals who are eligible for Guaranteed Issue:

☐ Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual ; or

☐ 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

☐ 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

☐ Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation; or

☐ 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 terminates coverage within 12 months of enrollment; or

☐ Upon *first* becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months; or

☐ Enrolled in a Medicare Part D Plan during the initial Part D enrollment period while enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and terminate the Medicare Supplement policy; or

☐ Other Guarantee Issue rights available under State law.

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

SC

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Medicare Supplement Policy

2010 Standardized Plan G ~ Yes

Attained Age Premium Rates

Rates Effective Upon Approval

Tobacco Use Tobacco Use

Attained Age	Female			Male		
	Preferred Select	Preferred	Standard	Preferred Select	Preferred	Standard
0-64	N/A		N/A	N/A		N/A
65	94.79		113.63	107.09		128.40
66	94.79		113.63	107.09		128.40
67	94.79	100.53	120.50	107.09	113.56	136.17
68	94.79	105.60	126.58	107.09	119.30	143.05
69	94.79	110.89	132.95	107.09	125.31	150.19
70	95.79	115.95	139.03	108.22	131.04	157.09
71	100.78	120.54	144.55	113.85	136.24	163.35
72	103.77	125.29	150.24	117.23	141.60	169.79
73	107.66	130.28	156.21	121.66	147.22	176.51
74	111.96	135.44	162.35	126.48	153.01	183.42
75	116.39	140.76	168.77	131.52	159.06	190.72
76	121.03	145.03	173.90	136.78	163.89	196.52
77	125.82	149.39	179.12	142.19	168.82	202.41
78	130.76	153.84	184.44	147.75	173.83	208.40
79	135.93	158.48	189.95	153.55	179.02	214.58
80	141.25	163.20	195.66	159.59	184.40	221.04
81	145.90	168.12	201.56	164.85	189.96	227.70
82	150.97	173.13	207.55	170.58	195.61	234.54
83	155.95	178.13	213.55	176.20	201.27	241.29
84	160.17	183.14	219.55	180.96	206.92	248.04
85	164.04	188.06	225.45	185.34	212.48	254.70
86	168.32	192.97	231.35	190.19	218.04	261.35
87	172.53	197.79	237.15	194.96	223.51	267.91
88	176.82	202.71	243.05	199.81	229.07	274.66
89	181.26	207.81	249.14	204.82	234.81	281.51
90	185.79	213.00	255.33	209.91	240.64	288.45
91	190.40	218.29	261.72	215.15	246.66	295.68
92	195.18	223.76	268.29	220.56	252.86	303.19
93	200.03	229.32	274.97	226.05	259.15	310.70
94	205.04	235.07	281.83	231.69	265.62	318.40
95	210.14	240.91	288.80	237.42	272.18	326.29
96	215.40	246.94	296.05	243.38	279.02	334.47
97	220.82	253.15	303.50	249.50	286.04	342.93
98	226.32	259.46	311.04	255.71	293.15	351.48
99+	231.98	265.95	318.88	262.15	300.53	360.32

Open Enrollment or Guaranteed Issue: Determine Underwriting Class based on Tobacco and HT/WT
Underwritten: Determine Underwriting Class based on Tobacco, HT/WT, and Preferred Select Medical Question
See UW Guide for detailed instructions

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)
B - Area Factor (see area factors below)
C - Input Household Discount (1.0 if not applicable, 0.93 if roommate HHD applies, 0.9 if dual HHD applies)
D - Input Activity Tracker Discount (1.0 if not applicable, 0.95 if discount applies)
E - Input Annual Pay Discount (1.0 if not applicable, 0.9 if discount applies)
F - Calculate Monthly Rate (rounded to the nearest penny) F=A*B*C*D*E

Quarterly, Semi-Annual, or Annual Rate

G - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)
H - Calculate Final Modal Billing Rate (rounded to the nearest penny) H=F*G

Roommate Household Discount: 7%

Dual Household Discount (applies if multiple people in the same Household have or are applying for American Heritage Life Insurance Company Medicare Supplement policies): 10%

Annual Pay Discount: 10%

Activity Tracker "Wearable" Discount: 5%

The rates above do not include a one time $25 policy fee.

Area Factors:

South Carolina Zip Codes	Factor
294, 295, 298, 299	1.040
Rest of State	0.970

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan N N = ?
Attained Age Premium Rates
Rates Effective Upon Approval

Attained Age	Female			Male		
	Preferred Select	Preferred	Standard	Preferred Select	Preferred	Standard
0-64	N/A		N/A	N/A		N/A
65	72.67		87.09	82.08		98.43
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67	72.67	77.06	92.35	82.08	87.04	104.38
68	72.67	80.95	97.02	82.08	91.44	109.66
69	72.67	85.01	101.89	82.08	96.03	115.12
70	73.43	88.89	106.56	82.94	100.43	120.42
71	77.26	92.42	110.79	87.26	104.42	125.15
72	79.55	96.08	115.17	89.85	108.55	130.11
73	82.53	99.87	119.70	93.23	112.82	135.23
74	85.80	103.80	124.47	96.97	117.31	140.67
75	89.19	107.87	129.30	100.76	121.86	146.11
76	92.70	111.08	133.17	104.74	125.51	150.43
77	96.40	114.45	137.21	108.92	129.32	155.01
78	100.22	117.90	141.34	113.23	133.21	159.68
79	104.16	121.44	145.56	117.67	137.19	164.43
80	108.24	125.07	149.96	122.32	141.33	169.44
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94	157.17	180.18	215.97	177.55	203.55	244.01
95	161.06	184.65	221.33	181.96	208.60	250.06
96	165.11	189.28	226.96	186.58	213.90	256.45
97	169.22	194.00	232.58	191.21	219.20	262.76
98	173.49	198.89	238.47	196.05	224.75	269.41
99+	177.83	203.86	244.36	200.89	230.31	276.07

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NATIONAL HEALTH INSURANCE COMPANY

Outline of Medicare Supplement Plans A, F, High Deductible F, G, N

This chart shows the benefit included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

YES ↓

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓		✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible										✓
Medicare Part B excess charges				✓						
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2023[2]					$6940[2]	$3470[2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2700 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

Attach VOIDED Check
Medicare Red white Blue card
Below Any Existing coverage card
Email to mrkshef@yahoo.com or my fax # 775-522-7777