Gerber Life Insurance Company

Application For Medicare Supplement Coverage

PLAN INFORMATION (to be completed by **Producer**)

NOTE: For ALL sections, ONLY complete the Applicant B information if to be insured.

APPLICANT **Policy Form**	**APPLICANT B** **Policy Form**
Requested Effective Date	Requested Effective Date
Premium Collected (**based on age at application date**) $ The initial premium includes a one-time policy fee of $25.00.	Premium Collected (**based on age at application date**) $ The initial premium includes a one-time policy fee of $25.00.
Initial Mode **A, S, Q, ACH**	Initial Mode **A, S, Q, ACH**
Renewal $	Renewal $
Renewal Mode **A, S, Q, B** (direct monthly not available)	Renewal Mode **A, S, Q, B** (direct monthly not available)

1. PLEASE READ THE FOLLOWING CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY.

Applicant	**Applicant B**
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address (if different from Applicant's)
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone No (_____)_____ (area code)	Home Phone No (_____)_____ (area code)
Current Age _____ Date of Birth_____/____/_____ mo day yr	Current Age _____ Date of Birth_____/____/_____ mo day yr
Male ☐ Female ☐	Male ☐ Female ☐
Social Security No	Social Security No
Medicare Health Insurance Card Number (if known)	Medicare Health Insurance Card Number (if known)
E-mail Address	E-mail Address
Height Weight Ft _____ In _____ Lbs _____	Height Weight Ft _____ In _____ Lbs _____

2. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

	Applicant	Applicant B
1. Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage?	Yes ☐ No ☐	Yes ☐ No ☐
2. Have you used tobacco in any form in the past 12 months?	Yes ☐ No ☐	Yes ☐ No ☐
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," what is your Part A effective date? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
If "NO," what is your eligibility date? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
2. Are you covered under Medicare Part B?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," what is your Part B effective date? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
If "NO," indicate date you plan to enroll. ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
3. Did you turn age 65 in the last six months?	Yes ☐ No ☐	Yes ☐ No ☐
4. Did you enroll in Medicare Part B in the last six months?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," indicate your effective date. ____/____/____ (Applicant) / ____/____/____ (Applicant B)		

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

3. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

To the Best of Your Knowledge:	Applicant	Applicant B
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.)	Yes ☐ No ☐	Yes ☐ No ☐
2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force?	Yes ☐ No ☐	Yes ☐ No ☐
(a) If "YES," with what company, and what plan do you have?		

Applicant	**Applicant B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date ____/____/____	Issue Date ____/____/____

(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy?	Yes ☐ No ☐	Yes ☐ No ☐
(c) If "YES," indicate termination date. ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
(d) **If "YES," have you received a copy of the replacement notice?**	Yes ☐ No ☐	Yes ☐ No ☐

If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.

3. 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.
START ____/____/____ (Applicant) END ____/____/____ / START ____/____/____ (Applicant B) END ____/____/____

(a) 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 ☐	Yes ☐ No ☐
(b) **If "YES," have you received a copy of the replacement notice?**	Yes ☐ No ☐	Yes ☐ No ☐

(c) Reason for termination/disenrollment? _____ (Applicant) / _____ (Applicant B)

(d) Planned date of termination/disenrollment? ____/____/____ (Applicant) / ____/____/____ (Applicant B)

	Applicant	Applicant B
(e) Was this your first time in this type of Medicare plan?	Yes ☐ No ☐	Yes ☐ No ☐
(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan?	Yes ☐ No ☐	Yes ☐ No ☐
(g) Is your former Medicare supplement or Medicare select policy/certificate still available?	Yes ☐ No ☐	Yes ☐ No ☐
4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.)	Yes ☐ No ☐	Yes ☐ No ☐
(a) If "YES," with what company and what kind of policy/certificate? (List below.)		

Applicant		**Applicant B**	
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate

(b) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank.
START ___/___/___ END ___/___/___ / START ___/___/___ END ___/___/___
Applicant Applicant B

(c) Reason for termination/disenrollment? _____ / _____
Applicant Applicant B

(d) Planned date of termination/disenrollment? _____ / _____
Applicant Applicant B

5. 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 met your "Share of Cost," please answer "NO" to this question.) If "YES,"	Yes ☐ No ☐	Yes ☐ No ☐
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	Yes ☐ No ☐	Yes ☐ No ☐
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	Yes ☐ No ☐	Yes ☐ No ☐
6. Producers shall list any other health insurance policies/certificates they have sold to the applicant.		
(a) List policies/certificates sold which are still in force.		

Applicant	**Applicant B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage / /	Effective Date of Coverage / /

(b) List policies/certificates sold in the past five (5) years which are no longer in force.

Applicant	**Applicant B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage / /	Effective Date of Coverage / /

If you are applying during Open Enrollment or a Guaranteed Issue period, SKIP SECTION 4 and GO TO SECTION 5.

4. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. Make sure all questions are answered by each applicant. If either you or Applicant B answer "YES" to any of the following questions 1-14, that person is not eligible for coverage.

To the Best of Your Knowledge:	Applicant	Applicant B
1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair?	Yes ☐ No ☐	Yes ☐ No ☐
2. Within the past five years, have you been diagnosed with or treated for kidney disease requiring dialysis, emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	Yes ☐ No ☐	Yes ☐ No ☐
3. Within the past 10 years, have you been diagnosed with or treated for Osteoporosis with fractures ?	Yes ☐ No ☐	Yes ☐ No ☐
4. Have you EVER been diagnosed with or treated for Parkinson's Disease or Multiple or Lateral Sclerosis , Cirrhosis , Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?	Yes ☐ No ☐	Yes ☐ No ☐
5. Have you EVER been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	Yes ☐ No ☐	Yes ☐ No ☐
6. Have you EVER been diagnosed with or treated for diabetes, in addition to 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 ☐	Yes ☐ No ☐
7. Do you have diabetes that has EVER required more than 50 units of insulin daily?	Yes ☐ No ☐	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 or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?	Yes ☐ No ☐	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 ☐	Yes ☐ No ☐
10. Within the past two years have you been diagnosed with or treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	Yes ☐ No ☐	Yes ☐ No ☐
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	Yes ☐ No ☐	Yes ☐ No ☐
12. Within the past five years, have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes ☐ No ☐	Yes ☐ No ☐
13. Have you been hospital confined three or more times in the last two years?	Yes ☐ No ☐	Yes ☐ No ☐
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes ☐ No ☐	Yes ☐ No ☐
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 and the condition in the following table.	Yes ☐ No ☐	Yes ☐ No ☐

Applicant (please attach a separate sheet if needed)		**Applicant B** (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	

5. PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

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

I wish to apply for a Medicare supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Gerber Life Insurance Company.

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

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

Premium Must Accompany Application

I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

_____ _____
(Signature of Licensed Producer) (Signature of Licensed Producer)

0413480

_____ _____
PRODUCER STAMP PRODUCER STAMP

ADDITIONAL INFORMATION: PART 4 - CON'T. HEALTH /MEDICAL QUESTIONS - Question #15		
Applicant (please attach a separate sheet if needed)		**Applicant B** (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	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

SECTION FOR ADDITIONAL COMMENTS	
Applicant (please attach a separate sheet if needed)	**Applicant B** (please attach a separate sheet if needed)

Gerber Life
Insurance Company

Calculate Your Premium

Medicare Supplement

Medicare Supplement Plan _____

Before you begin: *If you're not in your open enrollment or guarantee issue period, please go to page 2 to determine your eligibility for coverage.*

Line	Steps	Example Rate displayed is used for calculation purposes only.	Applicant's Premium	Applicant B's Premium
#1	**Premium** Write in your Med supp plan's premium from the Outline of Coverage provided.	$128.52		
#2	**Payment Options** To determine other payment schedules, multiply your monthly premium by: 3 to pay four times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	$128.52 monthly payment $385.56 quarterly payment $771.12 semiannual payment $1,542.24 annual payment		
#3	**Enrollment/Policy Fee** There is a one-time application fee of $25.00. **This will be collected with your initial payment and will NOT affect your renewal premiums amount.**	$128.52 + $25.00 = $153.52 Example shows initial payment (monthly schedule).		

Complete and return with application

T03_198

Height and Weight Chart

Eligibility

To determine whether you may purchase coverage, locate your height, then weight in the chart below. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time. If your weight is located in the Standard column, you may continue to step 1.

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

Medicare supplement insurance is underwritten by
Gerber Life Insurance Company
Administrative Office
P.O. Box 2271
Omaha, Nebraska 68103-2271
www.gerberlifegroup.com

Gerber Life
Insurance Company

Policy Delivery

Mail policy/policies to:

(a) Applicant ☐ Producer ☐

(b) Applicant B ☐ Producer ☐

Producer(s) Information

Producer Name Rick Plata Social Security No _____

Comm. % Share 100 Producer Phone No (888) 235-8060 Commission Code GB

Producer E-mail Address advisorrick @ msn.com

Producer FAX Number 888-391-0562

Producer Name _____ Social Security No _____

Comm. % Share _____ Producer Phone No (____) _____ Commission Code _____

Producer E-mail Address _____ @ _____

Producer FAX Number _____

Producer To Complete Only If Premium Is To Be Paid With A Business Check/Account

Initial Payment

Is the applicant:	Yes	No
(a) unemployed?	☐	☐
(b) employed, but not working for the business that is paying the premium?	☐	☐
(c) the business owner or spouse of the business owner?	☐	☐

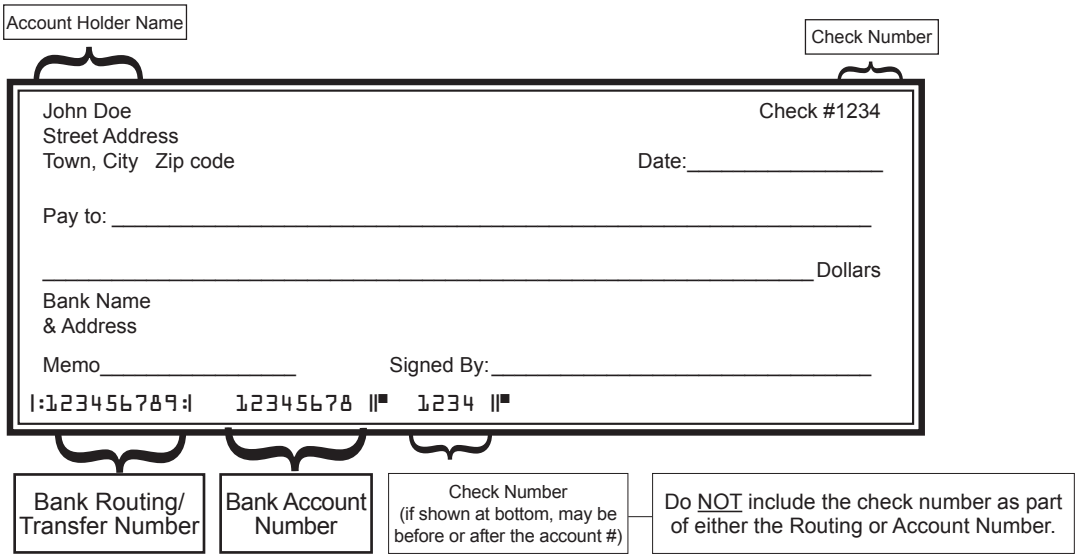
If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

Renewal Payment

Is the applicant:	Yes	No
(a) unemployed?	☐	☐
(b) employed, but not working for the business that is paying the premium?	☐	☐
(c) the business owner or spouse of the business owner?	☐	☐

If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

Instructions for Completion of Authorization for Electronic Funds Transfer (ACH/BSP) Form



The applicant may select one of three payment options indicated on the back side of this form. Instructions for each option are listed below. With each option, the form must be signed and dated.

Option A: Pay all premiums (1st month and monthly renewals) by Electronic Funds Transfer (EFT).
Automated Clearing House (ACH) is used for initial payment and **Bank Service Plan** (BSP) is used for renewal payments. When choosing to pay both the initial and monthly renewals by EFT, the applicant must complete the form and submit it with the application. DO NOT submit a signed check for payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account numbers, name of financial institution) on the form.

Option B: Pay 1st month by paper check and monthly renewals by BSP
When choosing to pay the initial premium via paper check and the monthly renewals by BSP, the applicant must complete the form and submit it with the application. A signed check for the initial monthly premium must be submitted with the application.

Option C: Pay 1st month by ACH and pay renewals by direct bill (monthly direct billing is not offered)
When choosing to pay the initial premium by ACH and renewal premiums by direct billing (quarterly, semiannually, or annually), the applicant must complete the form and submit it with the application. DO NOT submit a signed check for the initial premium payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account number, name of financial institution) on the form.

When choosing to pay initial premium by ACH, money will be withdrawn on the date the application is processed. This may be different from the monthly withdraw date selected for renewal premiums.

Payments cannot be postponed until a later date.

Payment from a third party, including any foundation, cannot be accepted.

All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Please complete the Electronic Funds Transfer form accurately and in its entirety, making sure that all required information is correct and complete on your Electronic Funds Transfer form prior to submission. In addition, please make sure that the premium amount is filled in on the Electronic Funds Transfer form so we can initiate a timely and accurate withdrawal from your client's bank account.

An example of how to find correct Routing and Account Numbers on your clients' checks is included at the top of this form. Do not include the check number as part of either the Routing or Account Number. The applicant's bank name is normally included above the Memo line on the check.

Gerber Life
Insurance Company

Please refer to instructions on the Front of this form.

Authorization for Electronic Funds Transfer (ACH/BSP)

This form is intended as authorization to debit your account. Please complete initial and renewal premium payments information below.

Medicare Supplement Premium Payment Options:	**Applicant A** YES	**Applicant A** NO	**Applicant B** YES	**Applicant B** NO
A. Pay premiums (1st month and monthly renewals) by Electronic Funds Transfer (**ACH** is used for initial payment and **BSP** is used for renewal payments.)	☐	☐	☐	☐
B. Pay 1st premium by signed paper check and pay monthly renewals by BSP	☐	☐	☐	☐
C. Pay initial premium by ACH and pay renewals by direct bill **(monthly direct billing is not offered)**	☐	☐	☐	☐
• If choosing Options A or C, list amount of initial premium withdrawal	$ _____		$ _____	
• If choosing Options A or B, select a withdrawal date for monthly renewal payments (circle one)	1st or 15th		1st or 15th	
• Is a Business Account being used to pay premiums?	☐	☐	☐	☐
• If yes, is the applicant:				
(a) Unemployed	☐	☐	☐	☐
(b) Employed, but not working for the business that is paying the premium	☐	☐	☐	☐
(c) The business owner or spouse of the business owner	☐	☐	☐	☐

If (A), (B), or (C) are "Yes," premiums CAN be paid with a business account.

Applicant A

Complete the information below. To avoid potential delays in processing, submit a copy of a voided check.

Account Type (check one): ☐Checking ☐Savings

_____
Name of Financial Institution

_____
Routing Number (first 9 digits on lower left side of check)

_____
Account Number
(Do NOT use Debit or Credit Card account numbers)

_____
Name as Shown on Account

Applicant B

Account Type (check one): ☐Checking ☐Savings

_____
Name of Financial Institution

_____
Routing Number (first 9 digits on the lower left side of check)

_____
Account Number
(Do NOT use Debit or Credit Card account numbers)

_____
Name as Shown on Account

IMPORTANT: Withdrawal date of the initial premium payment will occur when the application is processed and may be different than the monthly withdrawal date selected above.

I authorize Gerber Life Insurance Company ("Gerber") to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. I also authorize Gerber to collect any premium(s) due by bank draft withdrawal. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic funds transfer from my account to Gerber. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

_____
Authorized Signature as Shown on Account

_____
Date

_____
Authorized Signature as Shown on Account

_____
Date

Gerber Life
Insurance Company

Conditional Receipt

Check or Money Order Application

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

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

Applicant

Received of _____

this _____ day of

_____, _____

an application for Form _____ Policy

and/or Riders _____ and

Check or Money Order for _____ Dollars.

Should the Company decline to issue the insurance applied for, I hereby agree to return the above sum to the applicant.

Agent _____

Applicant B

Received of _____

this _____ day of

_____, _____

an application for Form _____ Policy

and/or Riders _____ and

Check or Money Order for _____ Dollars.

Should the Company decline to issue the insurance applied for, I hereby agree to return the above sum to the applicant.

Agent _____

NOTICE TO APPLICANT: Eligibility for the health and accident insurance applied for is conditional upon all of the following:

(a) payment of the full, initial premium; (b) written application; (c) satisfying the Company's underwriting standards.

If you are not eligible, no insurance or temporary or interim insurance of any kind will be effective.

Complete Receipt in full and leave with applicant at time of application.

Gerber Life Insurance Company - Notice of Information Practices

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

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

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

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

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

Give this notice to the applicant.

Gerber Life
Insurance Company

PLEASE SIGN AND RETURN THIS AUTHORIZATION WITH YOUR COMPLETED APPLICATION

Authorization To Disclose Personal Information To Gerber Life Insurance Company

Meanings of Terms

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes.

"Psychotherapy Notes" means: notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

"Specified Companies" means:

- The group of companies which presently includes Gerber Life Insurance Company and additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me to Gerber Life Insurance Company.

Purposes

The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits.

Potential for Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

Failure to Sign

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting
Gerber Life Insurance Company
P.O. Box 2271
Omaha, Nebraska 68103-2271

I realize that my right to revoke this authorization is limited to the extent that Gerber Life Insurance Company has taken action in reliance on the authorization or the law allows Gerber Life Insurance Company to contest the issuance of the policy or a claim under the policy.

Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Applicant acknowledges and agrees that if there is more than one proposed insured on this application, all information provided may be reviewed or shared with the other applicant. A completed and signed application will become part of each applicant's policy.

Names and Signatures

Name(s) used for medical records (if different than the name(s) below): _____

_____

Applicant	**Applicant B**
Printed Name of Proposed Applicant	Printed Name of Proposed Applicant
Signature of Proposed Applicant	Signature of Proposed Applicant
Date	Date

Gerber Life
Insurance Company

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

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Gerber Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

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

If you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

✗ _____

Signature of Agent, Broker or Other Representative

Gerber Life Insurance Company, P.O. Box 2271, Omaha, Nebraska 68103-2271

Applicant	**Applicant B**
Signature	Signature
Date	Date

1 - Home Office Copy 2 - Applicant Copy

Gerber Life
Insurance Company

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

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Gerber Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

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

If you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

✗ _____

Signature of Agent, Broker or Other Representative

Gerber Life Insurance Company, P.O. Box 2271, Omaha, Nebraska 68103-2271

Applicant	**Applicant B**
Signature	Signature
Date	Date

1 - Home Office Copy 2 - Applicant Copy

Gerber Life
Insurance Company

Medicare Select Policy Disclosure Agreement

I acknowledge receipt of the following information:

1. Outline of Coverage
2. Description of the restricted network provisions including:
   (a) network providers;
   (b) payments for coinsurance and deductibles when providers other than network providers are utilized;
   (c) coverage for emergency and urgently needed care and other out of service area coverage;
   (d) limitations on referrals to restricted network providers;
   (e) description of my rights to purchase a Medicare supplement policy of equal or lesser benefits offered in my state by Gerber Life Insurance Company;
   (f) Gerber Life Insurance Company's Quality Assurance Program; and
   (g) Gerber Life Insurance Company's Grievance Procedures.

I also understand the following:

Gerber Life Insurance Company does not recommend the purchase of a Medicare select policy if I live more than 30 miles from a network hospital; unless the network hospital is the closest hospital which offers this level of service.

I have received full and fair disclosure of the information described above.

Signature of the Proposed Applicant	Signature of the Proposed Applicant B
Date	Date

Please mail your completed form to:

Medicare Options

Attention: Rick Plata
23331 Via Sausalito
Moreno Valley, CA 92557

Or

Fax to: (888) 391- 0562

Enrollment questions, please call Rick Plata at (888) 235-8060.