Medicare Supplement

Application Transmittal Form

15-138-11 (08/15)

Fax applications and New Business documents ONLY to: 855.864.8526

Important:

- Only applications paying the initial premium by bank draft are eligible to be faxed.
- **DO NOT** collect premium with an application that is being faxed.
- All applications submitted with this form must be written by the same agent.
- Please use one transmittal per application unless submitting companions. Companions should be faxed in together.
- Do not mail in applications/forms once you have faxed them, original copies should be maintained in case of fax transmission problems.
- It is important to include phone/fax number below.
- **DO NOT** submit Pre-Underwriting Issues through the fax number above (2nd applications, replacement forms, or other additional documents).

Forms Sequence:

1. Application *(include Application Addendum, if applicable)*
2. Producer Statement
3. Health Information Authorization
4. Replacement Notice *(if applicable)*
5. Other state-specific required forms *(if applicable)*
6. Guaranteed Issue documentation *(if applicable)*
7. Signed Bank Draft Authorization

PLEASE PRINT LEGIBLY

Agent Name		Agent Code
Agent Phone Number	Agent Fax Number	Total No. of Pages Faxed (including this cover sheet):

Applicant Name	Plan Applied For	Initial Premium Amount to be drafted or charged *(include policy fee)*

All application questions should be directed to the Underwriting Department at 877.212.2346.

Application for

Medicare Supplement Insurance AOH5510

Americo Financial Life and Annuity Insurance Company
Medicare Supplement Administrative Office: PO Box 10812, Clearwater, FL 33757-8812

☒ New Business ☐ Coverage Change ☐ Reinstatement

Part I – Personal Information

Application#

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other____________

Last Name	First Name	MI	Gender ☐ Male ☐ Female

Street Address

City	State	ZIP

Birthdate *(mm/dd/yyyy)*	Age	Social Security Number	Height	Weight

Medicare ID Number	Requested Start Date *(if other than the Application Date)* ____________ *(mm/dd/yyyy)*

Daytime Phone	Evening Phone	Mobile Phone

Email Address

Part II – Plan Selection

☐ A ☐ C ☐ D ☐ F ☐ G ☐ N	**Nicotine Use:** Within the past 12 months, have you used nicotine products in any form? ☐ Yes ☐ No

Part III – Eligibility

State law allows a 6-month open enrollment period beginning with the first day of the first month in which you are both: (1) age 65 or older; and (2) enrolled in Medicare Part B. *If you are a qualified open enrollee, you may apply for and receive any Medicare Supplement Plan available from us.*

1. Are you covered under Medicare Part A? ☐ Yes ☐ No
   a. If **Yes**, what is your Part A start date? ____________
   b. If **No**, what is your eligibility date? ____________
2. Are you covered under Medicare Part B? ☐ Yes ☐ No
   a. If **Yes**, what is your Part B start date? ____________
   b. If **No**, what is your eligibility date? ____________
3. Have you enrolled in Medicare Part B more than once? ☐ Yes ☐ No
4. Did you turn 65 in the last 6 months? ☐ Yes ☐ No

Part IV – Medicare & Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are 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 this Application. *Please mark **Yes** or **No** below with an "X", to the best of your knowledge.*

PLEASE ANSWER ALL QUESTIONS

1. Are you applying during a guaranteed issue period? *(If **Yes**, please attach proof of eligibility.)* ☐ Yes ☐ No

2. Are you covered for Medical Assistance through the state Medicaid program? ☐ Yes ☐ No
   *NOTE TO APPLICANT: If you are participating in a "Spend Down Program" and have not met your "Share of the Cost", please answer **No** to this question.*
   a. Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
   b. Do you receive any benefits from Medicaid, OTHER THAN payments toward your Part B premium? ☐ Yes ☐ No

3. 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 *"Paid-to"* dates below. If you are still covered under this plan, leave *"End Date"* blank.

   Start Date ________________ **End Date**________________ *(mm/dd/yyyy)*

   b. 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 Replacement Notice.)* ☐ Yes ☐ No

   If so, with what company? ________________

   Policy Number: ________________

   Telephone Number: ________________ What plan do you have? ________________

   (i) Was this your first time in this type of Medicare Plan? ☐ Yes ☐ No

   (ii) Did you drop a Medicare Supplement policy or certificate to enroll in the Medicare Plan? ☐ Yes ☐ No

4. Do you have another Medicare Supplement policy or certificate in force? ☐ Yes ☐ No
   a. If so, with what company? ________________

   Policy or Certificate Number: ________________

   Telephone Number: ________________ What plan do you have? ________________

   b. If so, do you intend to replace your current Medicare Supplement policy or certificate with this policy? *(If **Yes**, complete Replacement Notice.)* ☐ Yes ☐ No

5. Have you had coverage under any other health insurance within the past 63 days? *(For example, an employer, union, or individual plan.)* ☐ Yes ☐ No
   a. If so, with what company? ________________

   (i) What kind of policy and plan number? ________________

   (ii) What are your dates of coverage under the policy?

   Start Date ________________ End Date________________ *(mm/dd/yyyy)*

Part V – General Information

1. You do not need more than one Medicare Supplement policy or certificate.
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 or certificate.
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. Upon receipt of your request, we will return to you that portion of the premium attributable to the period of your Medicaid eligibility, subject to an adjustment for paid claims. 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, effective as of the date of termination of Medicaid, if requested within 90 days of losing your 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 suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy or certificate 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 or certificate 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 or certificate under these circumstances, and later lose your employer or union based group health plan, your suspended Medicare Supplement policy or certificate or, if that is no longer available, a substantially equivalent policy or certificate, will be reinstituted if requested within 90 days of losing your employer or union based group health plan. If the Medicare Supplement policy or certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy or certificate was suspended, the reinstituted policy or certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of 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).

Part VI – Premium Payment & Administration

Initial Premium:____________________	Premium Mode/Method:

Part VII – Medical Questions

Do not answer any health questions if you are in an open enrollment or guaranteed issue period. Please see Part III and Part IV for an explanation of open enrollment/guaranteed issue period information.

NOTICE TO APPLICANT: Please answer all of the following questions. Please verify the accuracy and completeness of the medical information on this application. Incomplete or false information on this application could jeopardize future claims.
If you answer **YES** to any of the following questions 1-13, you are **not** eligible for coverage.

1. Are you currently or within the past 6 months been:
   a. Hospitalized, bedridden, confined to a wheelchair, or require the use of a motorized mobility aid? ☐ Yes ☐ No
   b. Residing in a nursing home or assisted living facility, or other professional care facility? ☐ Yes ☐ No
   c. Receiving home health care? ☐ Yes ☐ No
   d. Receiving assistance with Activities of Daily Living including eating, bathing, toileting, or dressing? ☐ Yes ☐ No
   e. Diagnosed with a Terminal Illness? ☐ Yes ☐ No

Part VII – Medical Questions *(continued)*

2. Do you currently receive care or treatment that requires administration of medications or physical therapy **in a medical facility** or by a licensed member of the medical profession, including but not limited to: joint injections to alleviate pain, infusions or for pain to joints, spine or other areas of the body, biologics, infusions, or treatments for chronic illness that must be administered by a licensed practitioner (excluding b12 injections)? ☐Yes ☐No
3. Do you currently have an implanted cardiac defibrillator? ☐Yes ☐No
4. Have you ever been diagnosed with, advised, or treated by a member of the medical profession for:
   a. Pulmonary Hypertension (excluding common high blood pressure), Emphysema, chronic obstructive pulmonary disease (COPD), or other chronic respiratory disorders (excluding seasonal asthma), or do you require the use of supplemental oxygen at any time of the day or night (excluding CPAP and BiPAP for sleep apnea)? ☐Yes ☐No
   b. Parkinson's disease, systemic lupus, myasthenia gravis, multiple dystrophy, or amyotrophic lateral sclerosis (ALS), Multiple Sclerosis, osteoporosis **with fractures**, cirrhosis, or chronic hepatitis or liver failure? ☐Yes ☐No
   c. Alzheimer's disease, senile dementia, or any other cognitive or memory disorder? ☐Yes ☐No
   d. Chronic kidney disease, kidney failure, renal insufficiency, or kidney disease requiring dialysis? ☐Yes ☐No
5. Have you ever been advised by a licensed member of the medical profession:
   a. that surgery, including cataract surgery, may be required within the next 12 months? ☐Yes ☐No
   b. to have surgery, medical tests, treatment, or therapy (including physical therapy) that has not yet been performed, or are you currently receiving therapy or treatment or awaiting test results? ☐Yes ☐No
   c. to have an organ transplant or have you ever had an organ transplant? ☐Yes ☐No
6. Have you ever been diagnosed with, advised, or treated by a licensed member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC) or Human Immunodeficiency Syndrome (HIV)? ☐Yes ☐No
7. Have you ever had an amputation **Not** caused by an injury or accident? ☐Yes ☐No
8. Have you ever been diagnosed with, received care or treatment for, or been advised by a licensed member of the medical profession to seek treatment for Diabetes in any form or been advised to take medication of any kind to reduce or control your blood sugar **in addition to**:
   a. Requiring more than 50 units of insulin daily? ☐Yes ☐No
   b. Ever being diagnosed by a licensed member of the medical profession with Coronary Artery Disease, Neuropathy, amputation, peripheral artery disease, heart disorder or disease, Stroke, Transient Ischemic Attack (TIA), kidney disease or insufficiency, CHF, Vascular Disease, Heart Valve Disease, Heart Rhythm Disturbances, or Retinopathy? ☐Yes ☐No
   c. Ever being diagnosed by a licensed member of the medical profession with Hypertension (High Blood Pressure) which has required hospitalization; or has, within the past 12 months, required you to take more than three (3) medications for hypertension or been diagnosed as not well controlled by a licensed member of the medical profession? ☐Yes ☐No
9. Within the past 2 years, have you been diagnosed with, advised, or treated by a licensed member of the medical profession for Cancer, metastasis, brain tumor, Lymphoma, Melanoma (including Merkel Cell, Melanoma, and Squamous Cell, but **not** including basal cell cancer of the skin), Alcoholism, Drug Abuse, or been advised by a licensed member of the medical profession to reduce alcohol intake? ☐Yes ☐No
10. In the past 2 years, have you been diagnosed with, advised, or treated by a licensed member of the medical profession for any mental or nervous disorder requiring hospitalization? ☐Yes ☐No
11. Within the past 2 years, have you:
    a. been advised by a licensed member of the medical profession to have a joint replacement not yet completed? ☐Yes ☐No
    b. had a joint replacement from which you are not completely recovered? ☐Yes ☐No
    c. been treated by a licensed member of the medical profession for rheumatoid arthritis or crippling or disabling arthritis? ☐Yes ☐No

Part VII – Medical Questions *(continued)*

12. Within the past 2 years, have you been diagnosed with, advised, or treated by a licensed member of the medical profession for:
    a. Heart attack? ☐Yes ☐No
    b. Stroke or TIA (Transient Ischemic Attack or "Mini Stroke")? ☐Yes ☐No
    c. Bypass or Stent placement in any artery? ☐Yes ☐No
    d. Initial installation of a Pacemaker? ☐Yes ☐No
    e. Initial diagnosis of Atrial Fibrillation or undergone Ablation procedure? ☐Yes ☐No
    f. Heart Valve Surgery for repair or replacement? ☐Yes ☐No
    g. Pulmonary Embolism? ☐Yes ☐No
    h. Congestive Heart Failure, enlarged heart, or Cardiomyopathy? ☐Yes ☐No
13. Within the past 2 years, have you received an initial diagnosis by a licensed member of the medical profession, or begun treatment for Coronary Artery Disease (CAD), Cerebrovascular Disease (CVD), or Peripheral Vascular Disease (PVD)? *(Answer "No" if treatment began prior to the last 2 years and for which you remain on medication prescribed by a licensed member of the medical profession and/or you have been told by a licensed member of the medical profession that you maintain good control.)* ☐Yes ☐No

Part VIII – Other Health Insurance Policies or Certificates

Listed below are all other health insurance policies or certificates I, the Producer, have (a) sold to the Applicant which are still in force; (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

Part IX – Agreement & Acknowledgment

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 coverage applied for, and (b) a "Guide to Health Insurance for People with Medicare."

I AUTHORIZE Americo to act on electronic and/or telephonic information from all parties specified in this application. This authorization may be revoked by sending written notice to Americo at its Medicare Supplement Administrative Office address. The absence of this authorization constitutes a rejection of this authorization.

I FULLY UNDERSTAND the questions contained in this Application. To the best of my knowledge and belief, the answers I provided are true and complete. I understand the Company may conduct a telephone interview with me regarding the answers. I understand and agree the coverage 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, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits and application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

____
Signed at (City and State)

Send policy to: ☐Applicant ☐Producer

____
Applicant's Signature

____
Application Date

____
Producer's Signature

____
Producer Number

____
Producer's Phone

Producer
Statement
AAA5510-AS

Americo Financial Life and Annuity Insurance Company
Medicare Supplement Administrative Office: PO Box 10812, Clearwater, FL 33757-8812

All questions must be completed

1. Did you meet with the Applicant in person? .... Yes ☐ No ☐
2. Did you complete this Application over the phone? .... Yes ☐ No ☐
3. State the name and relationship of any other person present when this Application was taken:

   Name:________________________ Relationship to Applicant:________________________
4. Did you review the Application for correctness and any omissions? .... Yes ☐ No ☐
5. Did the Applicant review the Application for correctness and any omissions? .... Yes ☐ No ☐
6. Are you related to the Proposed Insured? .... Yes ☐ No ☐

   If **Yes**, provide relationship:________________________

Replacement Information

7. Does the applicant have any existing Medicare Supplement coverage? .... Yes ☐ No ☐
   *(If **Yes**, complete the replacement notice and submit with the application. Application and replacement notice must be dated the same day.)*

I hereby certify that I have personally asked each question on this application to the applicant, that I have truly and accurately recorded on the application the information supplied by him/her, and that I have no reason to believe that the information provided is inaccurate or incomplete.

Print Producer's Name	Producer's Signature	Americo Agent Number	% Commission Split
	X		
	X		

Health Information

Authorization

AAA8555 (01/18)

AMERICO

Americo Financial Life and Annuity Insurance Company

This Authorization complies with the HIPAA Privacy Rule

Information regarding your insurability will be treated as confidential. Americo Financial Life and Annuity Insurance Company (Americo), is a member of MIB, Inc. (MIB). Americo, or its reinsurers, may make a brief report to MIB, 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, MIB may supply such company with the information in its file. Americo or its reinsurers may also release information to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. You may request to see the information kept in your MIB file. You may also contact MIB and seek correction of any errors in your file.

Your authorization permits any insurance or reinsurance company, health plan, licensed medical physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, records custodians, other medical or medical related facility, other health care provider that has provided services, treatment or payment to you or on your behalf, within the past 10 years ("Your Providers"), or clearing house, consumer reporting agency, or MIB , to disclose your entire medical record and any other protected health information, concerning you to Americo Financial Life and Annuity Insurance Company ("Americo") or its reinsurers employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and nicotine products, 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).

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

Your protected health information is to be disclosed under this Authorization so that Americo may: (1) underwrite your 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 for benefits; (4) administer coverage; and (5) conduct other legally permissible activities that relate to any coverage you have applied for with Americo.

This Authorization shall remain in force for 30 months following the date of your signature below, and a copy of this Authorization is as valid as the original. This Authorization may be revoked by sending a written request for revocation to Americo at PO Box 410288, Kansas City, MO 64141-0288, Attention: Legal Department; however, a revocation is not effective to the extent that any of Your Providers has relied on this Authorization or to the extent that Americo has a legal right to contest a claim under an insurance policy or to contest the policy itself. 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.

Your Providers may not refuse to provide treatment or payment for health care services if you refuse to sign this Authorization. If you refuse to sign this Authorization to release your complete medical record, Americo may not be able to process your application, or if coverage has been issued may not be able to make any benefit payments.

____
Name of Applicant *(please print)*

____
Applicant's Date of Birth

____
Signature of Applicant or Personal Representative

____
Date

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

Medicare Supplement

Replacement Notice AAA8550

AMERICO

Americo Financial Life and Annuity Insurance Company

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 the enclosed Medicare Supplement coverage issued by Americo Financial Life and Annuity 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)*:

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ 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

☐ Other (*please specify*):

1. Health conditions which you may presently have may not be immediately or fully covered under the new Medicare Supplement coverage. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present coverage.
2. State law provides that your replacement coverage may not contain new waiting periods, elimination periods or probationary periods. We will waive any time periods applicable to waiting periods, elimination periods or probationary periods in your new coverage for similar benefits to the extent such time was spent under your original coverage.
3. 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, if any. 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 you want to keep it.

______________________________ ______________

Signature of Agent, Broker, or Other Representative Date

____

Applicant's Signature

Ohio

Solicitation Form AOH8552

AMERICO
Americo Financial Life and Annuity Insurance Company

I, The Insurance Agent or Broker Certify:

That, I am an insurance agent or broker.

That, I am making the solicitation or sale on behalf of Americo Financial Life and Annuity Insurance Company.

That, I have no connection or affiliation with, and are not in any way sponsored by, the federal or state government, the social security administration, the Centers for Medicare and Medicaid services, or the Department of Health and Human Services.

Agent Name	Agent Phone No.
Address of Agent	
Name of Agency	Phone Number
Address of Agency	

I, The Applicant, understand that I have the right to:

Verify the information above by contacting the Ohio Department of Insurance:

Ohio Department of Insurance
50 W. Town Street, 3rd Floor-Suite 300
Columbus, OH 43215

Contact the agent or broker making the solicitation or sale at both an address and telephone number provided by the agent or broker;

Contact the insurance company, insurance companies or the insurance company administrative office on behalf of which the solicitation or sale was made at an address and telephone number provided by the agent or broker;

Pay my premium(s) directly to the insurance company's designated administrator, if I purchase a Medicare supplemental insurance policy.

Americo Financial Life and Annuity Insurance Company
Medicare Supplement Administrative Office
PO Box 10812, Clearwater, FL 33757-8812

I, The Applicant, acknowledge the receipt of this form.

____
Applicant's Signature

Medicare Supplement Administration
PO Box 10813
Clearwater, FL 33757-8813

Office: 1-877-212-2346
Fax: 1-816-701-2534
Online: https://service.iasadmin.com/ac

Bank Draft Authorization for Medicare Supplement

Policy Number *(if known)*:	**Insured:**

Please indicate below when you would like your account drafted. Many of our customers have requested the option to pay their premiums on the same day they receive Social Security or SSI payments. The options below allow you to select the date that best fits your needs. You may select any option regardless of whether or not you receive Social Security or SSI payments.

Part I – Select one of the following date options

Initial Premium Payment (choose one)	☐ Same as subsequent payment date selected below, on or after the requested Effective Date ☐ On the Policy Issue Date ☐ Paid by enclosed check	
Subsequent Premium Payments (choose one)	☐ 1st day of the Month ☐ 3rd day of the Month	☐ 2nd Wednesday of the Month ☐ 3rd Wednesday of the Month ☐ 4th Wednesday of the Month

Note: *If one of the dates above falls on a weekend or holiday, deduction will be on* ***prior*** *business day.*

Other, please specify a day of the month from 1 to 28 __________ ***(Note:*** *if this date falls on a weekend or holiday, deduction will be on* ***next*** *business day)*

Part II – Select one of the following payment options

☐ Checking ☐ Savings Branch/Bank Name: ____________________

Routing Number [ ]
Account Number [ ]

☐ Check here if this is a business account

To ensure accuracy, please include a voided check or deposit slip.

Part III – Complete name and address as shown on account

Accountholder Name: ____________________

Address (include City, State, and ZIP): ____________________

Part IV – Sign and Date

As a convenience to me, I hereby request and authorize the banking institution below (the "Bank") to pay and charge to my account drafts on my account by and payable to the order of the company who issued or assumed the policy listed below (the "Company") administering my insurance policy provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that the Bank's rights in respect to such draft shall be the same as if it were a check drawn on the bank and signed personally by me. **This authorization will remain in effect until revoked by me or the Company. Notifications should be sent to PO BOX 10813, Clearwater, FL 33757-8813. The toll-free number is 877.212.2346 and the customer service fax number is 816.701.2534.** I agree that the Bank shall be fully protected in honoring any such draft. I further agree that if any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, the Bank shall be under no liability whatsoever. Should any draft not be honored by the Bank upon presentation, I understand that this method of payment may be terminated.

I understand that Americo requires a 5 business day advance notice to set up, change, or discontinue my bank draft information. I also understand that my insurance policy may lapse if said draft is returned unpaid by my Bank, or if I discontinue payments, prior to receiving confirmation of draft processing from the Company. ***Please keep a copy of this authorization with your banking records.***

Signature ____________________ Date ____________________

Americo Financial Life and Annuity Insurance Company

AMERICO.
Americo Financial Life and Annuity Insurance Company
Medicare Supplement Administrative Office: PO Box 10812, Clearwater, FL 33757-8812

INFORMATION PRACTICES NOTICE

THIS NOTIFICATION MUST BE DELIVERED TO THE PROPOSED INSURED WHEN THE APPLICATION IS COMPLETED.

Thank you for your application. This notice is given to you at the time you apply for insurance to tell you about the kinds of information we may obtain in connection with your application. We rely primarily 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 limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have a right of access and correction with respect to this information. You have the right to receive, in writing, the specific reason for an adverse underwriting decision. If you wish a more detailed explanation of our information practices, please write us at: Americo Financial Life and Annuity Insurance Company, PO BOX 410288, Kansas City, MO 64141-0288, Attention: Underwriting/New Business Department. Any requests to correct, amend or alter will be responded to within 30 days. Within a seven year timeframe, information that is corrected will be provided to any person who is designated by the requesting party and who may have received the information in the prior two years. Any statement of disagreement made by a requesting party will be filed and made available to those reviewing it in the future.

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. However, Americo Financial Life and Annuity Insurance Company or its reinsurers may make a brief report to the MIB, Inc. formerly known as Medical Information Bureau, a nonprofit membership organization of life insurance companies operating as an information exchange for its members. If you apply to another MIB member company for life or health insurance or a claim is submitted to such a company, upon request the MIB will supply the company with the information it has in its file.

Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it has in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Fair Credit Reporting Act. The MIB's information office address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. The Company or its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.