

# 2012 STANDARD Medicare Supplement/ Life Insurance Plans

Issued by Forethought Life Insurance Company

ARIZONA



THINKING AHEAD<sup>SM</sup> FORE  
THOUGHT<sup>®</sup>

# 2012 Forethought® Standard Medicare Supplement Insurance Plans

You can rely on Forethought® Standard Medicare Supplement Plans to help pay your Medicare Part A and Medicare Part B charges that Medicare doesn't cover.

## What's more, you have:

- Five plans from which to select the coverage that best meets your needs.
- 30 days to review your Policy; if you're not happy with it, we'll refund your premium.
- Virtually no claims paperwork to file.



The Forethought Standard Medicare Supplement insurance is underwritten by:

**Forethought Life Insurance Company**  
**Administrative office**  
PO Box 14659  
Clearwater, FL 33766-4659

Choose the Forethought Standard Medicare Supplement Plan that's right for you.

# Choose the Forethought<sup>®</sup> plan that best fits your needs!

	MEDICARE PAYS	PLAN A PAYS	PLAN C PAYS	PLAN F PAYS	PLAN G PAYS	PLAN N PAYS
<b>Medicare Part A hospital coverage</b>						
Deductible			\$1,156	\$1,156	\$1,156	\$1,156
First 60 days	100%					
Coinsurance 61–90 days	All but \$289 a day	\$289 a day	\$289 a day	\$289 a day	\$289 a day	\$289 a day
Coinsurance 91–150 days (Lifetime Reserve)	All but \$578 a day	\$578 a day	\$578 a day	\$578 a day	\$578 a day	\$578 a day
Extended hospital coverage (up to an additional 365 days in your lifetime)		Eligible expenses	Eligible expenses	Eligible expenses	Eligible expenses	Eligible expenses
Benefit for blood	All but 3 pints	3 pints	3 pints	3 pints	3 pints	3 pints
<b>Hospice care</b>						
	All but limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	Medicare copayment/coinsurance	Medicare copayment/coinsurance	Medicare copayment/coinsurance	Medicare copayment/coinsurance
<b>Skilled nursing facility care</b>						
First 20 days	100%					
Coinsurance 21–100 days	All but \$144.50 a day		Up to \$144.50 a day	Up to \$144.50 a day	Up to \$144.50 a day	Up to \$144.50 a day
<b>Medicare Part B physician's services and supplies</b>						
Deductible			\$140	\$140		
Coinsurance	Generally 80%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%†
Excess benefits				100% up to Medicare's limit	100% up to Medicare's limit	
Benefit for blood	All but 3 pints	3 pints	3 pints	3 pints	3 pints	3 pints
<b>Other benefits*</b>						
Emergency care received outside the USA			80% to lifetime max of \$50,000	80% to lifetime max of \$50,000	80% to lifetime max of \$50,000	80% to lifetime max of \$50,000

\*Refer to the next page and your Outline of Coverage for more information.

† Subject to copayment for office and emergency room visits.

# Your care benefits

## Medicare Part A hospital coverage

The Forethought® Standard Medicare Supplement Plan pays the \$1,156 Part A (inpatient) deductible for Plans C, F, G and N for each benefit period.

**First 60 days** – After the Part A deductible, Medicare pays all eligible expenses for services from your first through 60th day of hospital confinement. Services include semi-private room and board, general nursing and miscellaneous hospital services and supplies.

**Coinsurance** – Plans A, C, F, G and N pay \$289 a day when you are hospitalized from the 61st day through the 90th day. When you are hospitalized from the 91st day through the 150th day, the Plans pay \$578 a day for each Lifetime Reserve day used.

**Extended hospital coverage** – If you are in the hospital longer than 150 days during a benefit period and you have exhausted your 60 days of Medicare lifetime reserve, Plans A, C, F, G and N pay the Part A Medicare eligible expenses for hospitalization, paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

**Benefit for blood** – Medicare has one calendar year deductible for blood that is the cost of the first three pints. Plans A, C, F, G and N pay the deductible.

**Skilled nursing facility care** – Medicare pays all eligible expenses for the first 20 days.

**Coinsurance** – Plans C, F, G and N pay up to \$144.50 from the 21st through the 100th day during which you receive skilled nursing care. You must enter a Medicare certified skilled nursing facility within 30 days of being hospitalized for at least three days.

**Hospice care benefit** – Plans A, C, F, G and N pay the copayment/coinsurance amount for all Part A Medicare eligible hospice care and respite care expenses.

## Medicare Part B physician services and supplies

**Deductible** – Plans C and F pay the \$140 calendar-year deductible.

**Coinsurance** – After the Part B deductible, Plans A, C, F and G generally pay 20% of eligible expenses for physician's services, supplies, physical and speech therapy, and ambulance service.

After the Part B deductible, Plan N generally pays 20% of the eligible expenses for physician's services, supplies, physical and speech therapy, and ambulance services except up to a \$20 copayment for office visits and up to a \$50 copayment for emergency room visits.

For hospital outpatient services, the copayment amount will be paid under a prospective payment system. If this system is not used, then generally 20% of eligible expenses will be paid.

**Excess benefits** – Your bill for Part B services and supplies may exceed the Medicare eligible expense. When that occurs, Plan F and G will pay 100% up to the charge limitation established by Medicare.

**Benefit for blood** – Medicare has one calendar year deductible for blood that is the cost of the first three pints. Plans A, C, F, G and N pay the deductible.

## Other benefits\*

**Emergency care received outside the U.S.** – After you pay a calendar-year deductible, Plans C, F, G and N pay you 80% of eligible expenses incurred during the first 60 days of a trip up to a lifetime maximum of \$50,000. Benefits are payable for medically necessary emergency care.

\*Refer to the next page and your Outline of Coverage for more information.

# Forethought® Medicare Supplement Plans

**A Forethought® Standard Medicare Supplement insurance policy** helps pay eligible expenses not paid for by Medicare Part A and Medicare Part B. There may be charges that exceed what Medicare and your Standard Medicare Supplement insurance policy will pay.

**“Medicare Eligible Expenses”** means expenses covered by Medicare to the extent recognized as reasonable and medically necessary by Medicare.

**Forethought Standard Medicare Supplement Plans will not pay for:**

- Any expense incurred before your Policy Date
- Services for which no charge is made
- Expenses paid by Medicare
- Hospital or skilled nursing facility confinement charges incurred prior to the effective date of coverage of the policy
- Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate

**Medicare Part A Eligible Expenses for hospital/skilled nursing facility care** include expenses for semi-private room and board, general nursing and miscellaneous services and supplies.

A **Benefit Period** begins the first full day you are hospitalized and ends when you have not been in a hospital or skilled nursing facility for 60 consecutive days.

**Medicare Part B Eligible Expenses for medical services** include expenses for physician’s services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service.

**Coinsurance** is the portion of the eligible expense not paid by Medicare and paid by Standard Medicare Supplement Plans.

**Benefits are paid to you,** your hospital or doctor.

**You have 31 days from your renewal date to pay your premium.** Your policy will stay in force during this 31-day grace period.

**Your Policy is guaranteed renewable.** Your policy cannot be canceled. It will be renewed as long as the premiums are paid on time and the information on your application is correct.

**You cannot be singled out for a rate increase** no matter how many times you receive benefits. Your premium changes only when the same premium change is made on all in force Forethought Standard Medicare Supplement policies of the same form issued to persons of your classification in the same geographic area of your state.

**This is a brief description** of your coverage. This brochure must be accompanied by the Outline of Coverage. For a complete description of benefits, exceptions and limitations, please read your Outline of Coverage and your Policy.

**Not connected with or endorsed by the United States government or the federal Medicare program.**

This is a solicitation of insurance and an agent will contact you by telephone.

\*Refer to the next page and your Outline of Coverage for more information.

**Benefit Plans A, C, F, G and N**  
**Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010**

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state.

**Basic Benefits:**

**Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

**Medical Expenses:** Part B coinsurance (generally 20% of Medicare-approved expenses), or copayment for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B coinsurance or copayments.

**Blood:** First three pints of blood each year.

**Hospice:** Part A coinsurance.

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance
		Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible	Part B Deductible	
				Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, Including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-Pocket limit \$4660 paid at 100% after limit reached	Out-of-Pocket limit \$2330; paid at 100% after limit reached		

\* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

## **PREMIUM INFORMATION**

We, Forethought Life Insurance Company, can raise your premium if (a) we change the premium rates which apply to all policies of this form issued by us and in-force in your state; (b) coverage under Medicare changes; or (c) you move to a different ZIP code location.

There will be a one-time enrollment fee of \$25.00 added to the first premium.

## **DISCLOSURES**

Use this Outline to compare benefits and premiums among policies.

## **READ YOUR POLICY VERY CAREFULLY**

This is only an Outline, describing your Policy's most important features. The Policy is your insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and Forethought Life Insurance Company.

## **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to Forethought Life Insurance Company, P.O. Box 14659, Clearwater, FL 33766-4659. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your premiums.

## **POLICY REPLACEMENT**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

## **NOTICE**

This policy may not fully cover all of your medical costs. Neither Forethought Life Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

## **COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new Policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your Policy and refuse to pay any claims if you leave out or falsify important medical information

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

## FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates \*

These rates apply to ZIP codes starting with: 854 through 865  
 and to these specific ZIP codes: 85321, 85325, 85328, 85333, 85334, 85336, 85341, 85344, 85346, 85347, 85348, 85349, 85350,  
 85352, 85356, 85357, 85359, 85360, 85364, 85365, 85366, 85367, 85369, 85371

### Standard Plans - Nonsmoker

Female				Issue				Male			
Plan A	Plan C	Plan F	Plan G	Plan N	Age	Plan A	Plan C	Plan F	Plan G	Plan N	
N/A	N/A	N/A	N/A	N/A	<65	N/A	N/A	N/A	N/A	N/A	
\$82.68	\$113.16	\$115.87	\$98.22	\$87.22	65	\$95.03	\$130.07	\$133.18	\$112.90	\$100.25	
82.68	113.16	115.87	98.22	87.22	66	95.03	130.07	133.18	112.90	100.25	
82.68	113.16	115.87	98.22	87.22	67	95.03	130.07	133.18	112.90	100.25	
84.49	115.66	118.42	100.39	89.14	68	97.12	132.94	136.11	115.39	102.46	
88.43	121.03	123.93	105.06	93.29	69	101.64	139.11	142.45	120.76	107.23	
91.16	124.78	127.77	108.31	96.18	70	104.78	143.42	146.86	124.49	110.55	
95.55	130.78	133.91	113.52	100.81	71	109.83	150.32	153.92	130.48	115.87	
99.48	136.16	139.42	118.19	104.95	72	114.34	156.50	160.25	135.85	120.63	
103.30	141.39	144.77	122.72	108.98	73	118.73	162.52	166.40	141.06	125.26	
106.71	146.06	149.56	126.79	112.59	74	122.66	167.89	171.91	145.73	129.41	
109.92	150.45	154.04	130.59	115.96	75	126.34	172.93	177.06	150.10	133.29	
112.94	154.58	158.28	134.17	119.16	76	129.82	177.68	181.93	154.22	136.96	
116.05	158.84	162.64	137.87	122.43	77	133.39	182.57	186.94	158.47	140.72	
119.23	163.20	167.11	141.66	125.79	78	137.05	187.59	192.08	162.83	144.59	
122.52	167.69	171.70	145.56	129.26	79	140.83	192.75	197.36	167.31	148.57	
125.89	172.30	176.43	149.55	132.81	80	144.70	198.05	202.79	171.90	152.66	
126.52	173.16	177.31	150.30	133.48	81	145.42	199.04	203.81	172.76	153.42	
127.15	174.03	178.19	151.06	134.14	82	146.15	200.03	204.82	173.63	154.18	
127.79	174.90	179.09	151.82	134.82	83	146.88	201.03	205.85	174.50	154.96	
128.42	175.77	179.99	152.57	135.49	84	147.61	202.04	206.88	175.37	155.73	
129.06	176.65	180.88	153.33	136.16	85	148.35	203.05	207.91	176.24	156.51	
129.71	177.54	181.79	154.10	136.85	86	149.09	204.07	208.95	177.13	157.30	
130.36	178.43	182.69	154.87	137.53	87	149.84	205.09	209.99	178.01	158.08	
131.01	179.32	183.60	155.65	138.22	88	150.59	206.11	211.04	178.91	158.87	
131.67	180.21	184.53	156.43	138.90	89	151.34	207.14	212.10	179.80	159.66	
132.33	181.11	185.45	157.21	139.60	90	152.10	208.17	213.16	180.70	160.46	
132.99	182.02	186.38	157.99	140.30	91	152.86	209.22	214.23	181.60	161.26	
133.65	182.93	187.31	158.78	141.00	92	153.62	210.26	215.30	182.51	162.07	
134.18	183.67	188.06	159.42	141.57	93	154.23	211.11	216.16	183.24	162.72	
134.77	184.47	188.89	160.11	142.18	94	154.91	212.03	217.11	184.04	163.43	
135.09	184.90	189.33	160.49	142.52	95	155.28	212.53	217.62	184.47	163.82	
135.09	184.90	189.33	160.49	142.52	96	155.28	212.53	217.62	184.47	163.82	
135.09	184.90	189.33	160.49	142.52	97	155.28	212.53	217.62	184.47	163.82	
135.09	184.90	189.33	160.49	142.52	98	155.28	212.53	217.62	184.47	163.82	
135.09	184.90	189.33	160.49	142.52	99	155.28	212.53	217.62	184.47	163.82	

\* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively



## FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates \*

These rates apply to ZIP codes starting with: 850 through 852  
 and to these specific ZIP codes: 85301, 85302, 85303, 85304, 85305, 85306, 85307, 85308, 85309, 85310, 85311, 85312, 85313, 85318, 85320, 85322, 85323, 85324, 85326, 85327, 85329, 85331, 85332, 85335, 85337, 85338, 85339, 85340, 85342, 85343, 85345, 85351, 85353, 85354, 85355, 85358, 85361, 85362, 85363, 85372, 85373, 85374, 85375, 85376, 85377, 85378, 85379, 85380, 85381, 85382, 85383, 85385, 85387, 85388, 85390, 85392, 85395, 85396

### Standard Plans - Nonsmoker

Plan A	Female			Issue Age			Male			
	Plan C	Plan F	Plan G	Plan N	Age	Plan A	Plan C	Plan F	Plan G	Plan N
N/A	N/A	N/A	N/A	N/A	<65	N/A	N/A	N/A	N/A	N/A
\$90.95	\$124.48	\$127.46	\$108.04	\$95.94	65	\$104.53	\$143.08	\$146.50	\$124.19	\$110.28
90.95	124.48	127.46	108.04	95.94	66	104.53	143.08	146.50	124.19	110.28
90.95	124.48	127.46	108.04	95.94	67	104.53	143.08	146.50	124.19	110.28
92.94	127.23	130.26	110.43	98.05	68	106.83	146.23	149.72	126.93	112.71
97.27	133.13	136.32	115.57	102.62	69	111.80	153.02	156.70	132.84	117.95
100.28	137.26	140.55	119.14	105.80	70	115.26	157.76	161.55	136.94	121.61
105.11	143.86	147.30	124.87	110.89	71	120.81	165.35	169.31	143.53	127.46
109.43	149.78	153.36	130.01	115.45	72	125.77	172.15	176.28	149.44	132.69
113.63	155.53	159.25	134.99	119.88	73	130.60	178.77	183.04	155.17	137.79
117.38	160.67	164.52	139.47	123.85	74	134.93	184.68	189.10	160.30	142.35
120.91	165.50	169.44	143.65	127.56	75	138.97	190.22	194.77	165.11	146.62
124.23	170.04	174.11	147.59	131.08	76	142.80	195.45	200.12	169.64	150.66
127.66	174.72	178.90	151.66	134.67	77	146.73	200.83	205.63	174.32	154.79
131.15	179.52	183.82	155.83	138.37	78	150.76	206.35	211.29	179.11	159.05
134.77	184.46	188.87	160.12	142.19	79	154.91	212.03	217.10	184.04	163.43
138.48	189.53	194.07	164.51	146.09	80	159.17	217.86	223.07	189.09	167.93
139.17	190.48	195.04	165.33	146.83	81	159.96	218.94	224.19	190.04	168.76
139.87	191.43	196.01	166.17	147.55	82	160.77	220.03	225.30	190.99	169.60
140.57	192.39	197.00	167.00	148.30	83	161.57	221.13	226.44	191.95	170.46
141.26	193.35	197.99	167.83	149.04	84	162.37	222.24	227.57	192.91	171.30
141.97	194.32	198.97	168.66	149.78	85	163.19	223.36	228.70	193.86	172.16
142.68	195.29	199.97	169.51	150.54	86	164.00	224.48	229.85	194.84	173.03
143.40	196.27	200.96	170.36	151.28	87	164.82	225.60	230.99	195.81	173.89
144.11	197.25	201.96	171.22	152.04	88	165.65	226.72	232.14	196.80	174.76
144.84	198.23	202.98	172.07	152.79	89	166.47	227.85	233.31	197.78	175.63
145.56	199.22	204.00	172.93	153.56	90	167.31	228.99	234.48	198.77	176.51
146.29	200.22	205.02	173.79	154.33	91	168.15	230.14	235.65	199.76	177.39
147.02	201.22	206.04	174.66	155.10	92	168.98	231.29	236.83	200.76	178.28
147.60	202.04	206.87	175.36	155.73	93	169.65	232.22	237.78	201.56	178.99
148.25	202.92	207.78	176.12	156.40	94	170.40	233.23	238.82	202.44	179.77
148.60	203.39	208.26	176.54	156.77	95	170.81	233.78	239.38	202.92	180.20
148.60	203.39	208.26	176.54	156.77	96	170.81	233.78	239.38	202.92	180.20
148.60	203.39	208.26	176.54	156.77	97	170.81	233.78	239.38	202.92	180.20
148.60	203.39	208.26	176.54	156.77	98	170.81	233.78	239.38	202.92	180.20
148.60	203.39	208.26	176.54	156.77	99	170.81	233.78	239.38	202.92	180.20

\* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively

**FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates \***

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 and to these specific ZIP codes: 85301, 85302, 85303, 85304, 85305, 85306, 85307, 85308, 85309, 85310, 85311, 85312, 85313,  
 85318, 85320, 85322, 85323, 85324, 85326, 85327, 85329, 85331, 85332, 85335, 85337, 85338, 85339, 85340, 85342, 85343, 85345,  
 85351, 85353, 85354, 85355, 85358, 85361, 85362, 85363, 85372, 85373, 85374, 85375, 85376, 85377, 85378, 85379, 85380, 85381,  
 85382, 85383, 85385, 85387, 85388, 85390, 85392, 85395, 85396

**Standard Plans - Smoker**

Plan A	Female			Issue Age		Male			Plan N	
	Plan C	Plan F	Plan G	Plan N	Age	Plan A	Plan C	Plan F		Plan G
N/A	N/A	N/A	N/A	N/A	<65	N/A	N/A	N/A	N/A	N/A
\$104.53	\$143.08	\$146.50	\$124.19	\$110.28	65	\$120.15	\$164.45	\$168.39	\$142.75	\$126.75
104.53	143.08	146.50	124.19	110.28	66	120.15	164.45	168.39	142.75	126.75
104.53	143.08	146.50	124.19	110.28	67	120.15	164.45	168.39	142.75	126.75
106.83	146.23	149.72	126.93	112.71	68	122.79	168.08	172.10	145.89	129.55
111.80	153.02	156.70	132.84	117.95	69	128.51	175.89	180.10	152.68	135.58
115.26	157.76	161.55	136.94	121.61	70	132.48	181.34	185.68	157.40	139.78
120.81	165.35	169.31	143.53	127.46	71	138.86	190.06	194.61	164.98	146.50
125.77	172.15	176.28	149.44	132.69	72	144.57	197.88	202.62	171.77	152.53
130.60	178.77	183.04	155.17	137.79	73	150.12	205.48	210.40	178.35	158.38
134.93	184.68	189.10	160.30	142.35	74	155.09	212.28	217.36	184.26	163.63
138.97	190.22	194.77	165.11	146.62	75	159.74	218.65	223.87	189.78	168.53
142.80	195.45	200.12	169.64	150.66	76	164.14	224.65	230.03	195.00	173.16
146.73	200.83	205.63	174.32	154.79	77	168.65	230.84	236.36	200.37	177.93
150.76	206.35	211.29	179.11	159.05	78	173.28	237.18	242.86	205.88	182.82
154.91	212.03	217.10	184.04	163.43	79	178.06	243.71	249.54	211.54	187.85
159.17	217.86	223.07	189.09	167.93	80	182.95	250.40	256.40	217.35	193.02
159.96	218.94	224.19	190.04	168.76	81	183.87	251.66	257.69	218.44	193.97
160.77	220.03	225.30	190.99	169.60	82	184.79	252.91	258.97	219.53	194.94
161.57	221.13	226.44	191.95	170.46	83	185.71	254.18	260.27	220.63	195.92
162.37	222.24	227.57	192.91	171.30	84	186.64	255.45	261.57	221.74	196.90
163.19	223.36	228.70	193.86	172.16	85	187.57	256.73	262.88	222.84	197.89
164.00	224.48	229.85	194.84	173.03	86	188.51	258.02	264.19	223.96	198.88
164.82	225.60	230.99	195.81	173.89	87	189.45	259.30	265.51	225.07	199.87
165.65	226.72	232.14	196.80	174.76	88	190.40	260.60	266.84	226.20	200.87
166.47	227.85	233.31	197.78	175.63	89	191.35	261.90	268.17	227.34	201.87
167.31	228.99	234.48	198.77	176.51	90	192.31	263.21	269.51	228.47	202.88
168.15	230.14	235.65	199.76	177.39	91	193.27	264.53	270.86	229.61	203.90
168.98	231.29	236.83	200.76	178.28	92	194.24	265.85	272.22	230.76	204.92
169.65	232.22	237.78	201.56	178.99	93	195.01	266.92	273.31	231.68	205.73
170.40	233.23	238.82	202.44	179.77	94	195.87	268.08	274.51	232.69	206.64
170.81	233.78	239.38	202.92	180.20	95	196.33	268.72	275.15	233.24	207.13
170.81	233.78	239.38	202.92	180.20	96	196.33	268.72	275.15	233.24	207.13
170.81	233.78	239.38	202.92	180.20	97	196.33	268.72	275.15	233.24	207.13
170.81	233.78	239.38	202.92	180.20	98	196.33	268.72	275.15	233.24	207.13
170.81	233.78	239.38	202.92	180.20	99	196.33	268.72	275.15	233.24	207.13

\* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively

**PLAN A  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\* A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul>	All but \$1,156 All but \$289 a day  All but \$578 a day  \$0 \$0	\$0 \$289 a day  \$578 a day  100% of Medicare Eligible Expenses \$0	\$1,156 (Part A Deductible) \$0  \$0  \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital. First 20 days 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$144.50 a day \$0		\$0 Up to \$144.50 a day All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**\*\*NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN A  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\* Once You have been billed \$140 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES</b> – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$140 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$140 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$140 (Part B Deductible) \$0
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**PLAN C  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\* A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90th day 91 <sup>st</sup> day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul>	All but \$1,156 All but \$289 a day  All but \$578 a day  \$0 \$0	\$1,156 (Part A Deductible) \$289 a day  \$578 a day  100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital. First 20 days 21 <sup>st</sup> thru 100th day 101 <sup>st</sup> day and after	All approved amounts All but \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

**\*\*NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the Policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN C  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\* Once You have been billed \$140 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$140 (Part B Deductible) Generally 20%	\$0 \$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$140 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$140 (Part B Deductible) 20%	\$0 \$0 \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**PLAN F  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\* A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90th day 91 <sup>st</sup> day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul>	All but \$1,156 All but \$289 a day  All but \$578 a day  \$0 \$0	\$1,156 (Part A Deductible) \$289 a day  \$578 a day  100% of Medicare Eligible Expenses \$0	\$0 \$0  \$0  \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21 <sup>st</sup> thru 100th day 101 <sup>st</sup> day and after	All approved amounts All but \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

**\*\*NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN F  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\* Once You have been billed \$140 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$140 (Part B Deductible) Generally 20%	\$0 \$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$140 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$140 (Part B Deductible) 20%	\$0 \$0 \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**PLAN G  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\* A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days 61<sup>st</sup> thru 90th day 91<sup>st</sup> day and after:</p> <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:               <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul>	<p>All but \$1,156 All but \$289 a day</p> <p>All but \$578 a day</p> <p>\$0 \$0</p>	<p>\$1,156 (Part A Deductible) \$289 a day \$578 a day 100% of Medicare Eligible Expenses \$0</p>	<p>\$0 \$0 \$0 \$0** All Costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.</p> <p>First 20 days 21<sup>st</sup> thru 100th day 101<sup>st</sup> day and after</p>	<p>All approved amounts All but \$144.50 a day \$0</p>	<p>\$0 Up to \$144.50 a day \$0</p>	<p>\$0 \$0 All Costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness</p>	<p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment / coinsurance</p>	<p>\$0</p>

**\*\*NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN G  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\* Once You have been billed \$140 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$140 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$140 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$140 (Part B Deductible) \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**PLAN N  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\* A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90th day 91 <sup>st</sup> day and after: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1,156 All but \$289 a day  All but \$578 a day  \$0 \$0	\$1,156 (Part A Deductible) \$289 a day  \$578 a day  100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21 <sup>st</sup> thru 100th day 101 <sup>st</sup> day and after	All approved amounts All but \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

**\*\*NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN N  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\* Once You have been billed \$140 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT</b>, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.                      First \$140 of Medicare-approved amounts*                      Remainder of Medicare-approved amounts</p>	<p>\$0                      Generally 80%</p>	<p>\$0                      Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense</p>	<p>\$140 (Part B Deductible)                      Up to \$20 per office visit and up to \$50 per emergency room visit.                      The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</p>
<p><b>Part B Excess Charges</b>                      (Above Medicare-approved amounts)</p>	<p>\$0</p>	<p>\$0</p>	<p>All Costs</p>
<p><b>BLOOD</b>                      First 3 pints                      Next \$140 of Medicare-approved amounts*                      Remainder of Medicare-approved amounts</p>	<p>\$0                      \$0                      80%</p>	<p>All Costs                      \$0                      20%</p>	<p>\$0                      \$140 (Part B Deductible)                      \$0</p>
<p><b>CLINICAL LABORATORY SERVICES</b>                      – TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0</p>

**PLAN N**

**PARTS A & B**

<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> <ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment</li> </ul> First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100%	\$0	\$0
	\$0 80%	\$0 20%	\$140 (Part B Deductible) \$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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# Agent checklist for completing the Medicare Supplement / Life Insurance Application



This packet contains the following forms needed to complete an Application For Medicare Supplement Insurance and Life Insurance. Please tear out the **application** and all pages marked **"RETURN TO COMPANY"** and leave the remaining pages with the applicant(s). Please review the following information carefully and complete all needed forms:

- Application For Medicare Supplement Insurance and Life Insurance (Form MSAP1000-01 or MSAPC1000-01)
  - Medicare Supplement – If the applicant(s) is applying during Open Enrollment or a Guaranteed Issue period, Section 4 is not required to be completed
  - Life Insurance – Sections 4, 5 and 6 are required when the applicant(s) is applying for life insurance
  - Section 7 should be completed only if the applicant(s) would like his/her payments to be deducted automatically from his/her checking/savings account. This option applies only if premiums are paid monthly
- Agent Certification (Form AGTCRT10-01) – This form must be signed by the agent and by the applicant(s).
- Calculate your premium – This form is used to calculate the correct life insurance premium and, in coordination with the Outline of Coverage, to calculate the correct Medicare Supplement premium. This form must be returned with the application.
- Fax Transmittal – Follow the instructions on this form only if the applicant(s) elects to pay premiums using ACH and you are submitting the underwriting documents via fax instead of regular mail.
- Authorization to Release Confidential Medical Information (Form MS-HIPAA10-01-AZ) – Must be completed **only** if applying outside Open Enrollment or a Guaranteed Issue period for Medicare Supplement **or** if applying for life insurance. If both spouses are applying for coverage on the same application, then both must sign the form.
- Notice to Applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage (Form MS-RN10-01) – This form must be completed if replacement of an existing Medicare Supplement policy is involved. One signed copy must be returned to the Administrative office and the other signed copy must be left with the applicant(s).
- Notice for Replacement of Life Insurance or Annuities (A7012-02) – This form must be completed if replacement of existing life insurance is involved. One signed copy must be returned to the Administrative office and the other signed copy must be left with the applicant(s).
- Investigative Consumer Report Notice to Applicant, Medical Information Bureau Disclosure Notice, and Medicare Supplement/Select Initial Premium Receipt (MSREC-01) – The Initial Premium Receipt must be left with the applicant(s) and the full modal premium is required with all applications.

**Please note, you are also required to provide the applicant(s) with the following items:**

- Guide to Health Insurance for People with Medicare
- Outline of Coverage (Form MSOC10-01)

**Premiums and policy fee**

Utilize the Forethought® Freedom<sup>SM</sup> final expense premium chart to determine the correct monthly life insurance premium. Utilize the Outline of Coverage to determine Medicare Supplement premiums.

- Determine ZIP code where the client resides and find the correct rate page for that ZIP code
- Determine Plan
- Determine if tobacco or non-tobacco use
- Find age/gender – Verify that the age and date of birth are the exact age as of the application date, this will be your base monthly premium
- Use the Calculate your premium form to adjust the monthly premium for different modes and to add the policy fee
- A voided check needs to be submitted with the Application for EFT

There will be a one-time Medicare Supplement application fee of \$25.00 that must be collected with each applicant's initial payment. If both spouses are written on the same application, \$50.00 in fees must be collected. This will not affect the renewal premiums.

**Mailing Address**

Forethought Life Insurance Company  
Administrative office  
P.O. Box 14659  
Clearwater, FL 33766-4659

**Overnight/Express Address**

Forethought Life Insurance Company  
Administrative office  
2536 Countryside Boulevard, Suite 501  
Clearwater, FL 33763

**FAX Number for New Business - EFT Applications 1-855-808-0944**



Forethought Life Insurance Company  
 One Forethought Center  
 Batesville, Indiana 47006

# APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE AND LIFE INSURANCE

Administrative Office:  
 P. O. Box 14659  
 Clearwater, FL 33766-4659

## MEDICARE SUPPLEMENT PLAN INFORMATION (To be completed by Producer)

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

APPLICANT	
Medicare Supplement Standard Plan	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> N
Medicare Supplement Select Plan (not available in all states)	<input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> N
Requested Effective Date	Mail Policy To <input type="checkbox"/> Insured <input type="checkbox"/> Agent
Initial Premium Collected \$	Renewal Premium \$
Renewal Premium Mode <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly EFT	
APPLICANT B	
Medicare Supplement Standard Plan	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> N
Medicare Supplement Select Plan (not available in all states)	<input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> N
Requested Effective Date	Mail Policy To <input type="checkbox"/> Insured <input type="checkbox"/> Agent
Initial Premium Collected \$	Renewal Premium \$
Renewal Premium Mode <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly EFT	

**SECTION 1 - IF APPLYING FOR MEDICARE SUPPLEMENT INSURANCE AND/OR LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS COMPLETELY.**

APPLICANT			
Last Name	First	M.I.	
Mailing Address			
Residential Address (if different from Mailing Address)			
City		State	Zip
Age	Date of Birth	State of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone # ( ) -		E-Mail Address	
Social Security Number		Height	Weight
Medicare Health Insurance Card Number (if known)			
Have you used tobacco in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
APPLICANT B			
Last Name	First	M.I.	
Mailing Address			
Residential Address (if different from Mailing Address)			
City		State	Zip
Age	Date of Birth	State of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone # ( ) -		E-Mail Address	
Social Security Number		Height	Weight
Medicare Health Insurance Card Number (if known)			
Have you used tobacco in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**SECTION 2 - IF APPLYING FOR MEDICARE SUPPLEMENT INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.**

1. Have you received a copy of the Guide to Health Insurance for People with Medicare and the Outline of Coverage?	<b>APPLICANT</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>APPLICANT B</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>To the Best of Your Knowledge:</b>		
1. Are you covered under Medicare Part A: If "YES," what is your Part A effective date? _____/_____ <div style="text-align: center;">Applicant                      Applicant B</div> If "NO," what is your eligibility date? _____/_____ <div style="text-align: center;">Applicant                      Applicant B</div>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you covered under Medicare Part B? If "YES," what is your Part B effective date? _____/_____ <div style="text-align: center;">Applicant                      Applicant B</div> If "NO," indicate date you plan to enroll. _____/_____ <div style="text-align: center;">Applicant                      Applicant B</div>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did you turn age 65 in the last six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Did you enroll in Medicare Part B in the last six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. If "YES," indicate your effective date. _____/_____ <div style="text-align: center;">Applicant                      Applicant B</div>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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 accepted 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.**

**SECTION 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.**

<b>To the Best of Your Knowledge:</b>	<b>APPLICANT</b>	<b>APPLICANT B</b>
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have another Medicare Supplement Insurance policy or certificate in force (Select or Standard)? (a) If "YES," please complete the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**APPLICANT**

Name of Company	Policy/Certificate Number
Plan	Issue Date

**APPLICANT B**

Name of Company	Policy/Certificate Number
Plan	Issue Date

(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) If "YES," indicate termination date. _____/_____ <div style="text-align: center;">Applicant                      Applicant B</div>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If "YES," have you received a copy of the replacement notice?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>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.</b>		
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 _____ END _____ / START _____ END _____ <div style="text-align: center;">Applicant                      Applicant B</div>		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(b) If "YES," have you received a copy of the <b>replacement notice</b> ? (c) Reason for termination/disenrollment? _____/_____ <div style="display: flex; justify-content: space-between;"> <span><b>Applicant</b></span> <span><b>Applicant B</b></span> </div> (d) Planned date of termination/disenrollment? _____/_____ <div style="display: flex; justify-content: space-between;"> <span><b>Applicant</b></span> <span><b>Applicant B</b></span> </div> (e) Was this your first time in this type of Medicare plan? (f) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan? (g) Is your former Medicare supplement or Medicare Select policy/certificate still available? 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.) (a) If "YES," with what company and what kind of policy/certificate?(list below)	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
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**APPLICANT**

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

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 _____ <div style="display: flex; justify-content: space-between;"> <span><b>Applicant</b></span> <span><b>Applicant B</b></span> </div> (c) Reason for termination/disenrollment? _____/_____ <div style="display: flex; justify-content: space-between;"> <span><b>Applicant</b></span> <span><b>Applicant B</b></span> </div> (d) Planned date of termination/disenrollment? _____/_____ <div style="display: flex; justify-content: space-between;"> <span><b>Applicant</b></span> <span><b>Applicant B</b></span> </div>		
--	--	--

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," (a) Will Medicaid pay your premiums for this Medicare supplement policy? (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
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**APPLICANT** *(attach a separate sheet if needed)*

Name of Company	Policy/Certificate #
-----------------	----------------------

Description of Benefits	Effective Date of Coverage
-------------------------	----------------------------

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

Name of Company	Policy/Certificate #
-----------------	----------------------

Description of Benefits	Effective Date of Coverage
-------------------------	----------------------------

**APPLICANT B** *(attach a separate sheet if needed)*

Name of Company	Policy/Certificate #
-----------------	----------------------

Description of Benefits	Effective Date of Coverage
-------------------------	----------------------------

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

Name of Company	Policy/Certificate #
-----------------	----------------------

Description of Benefits	Effective Date of Coverage
-------------------------	----------------------------

**SECTION 4**

**IF APPLYING FOR ONLY MEDICARE SUPPLEMENT INSURANCE:**

- During Open Enrollment or a Guaranteed Issue period, SKIP SECTION 4 and GO TO SECTION 5.
- NOT during Open Enrollment or a Guaranteed Issue period, PLEASE ANSWER ALL QUESTIONS.

**IF APPLYING FOR LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS. If either you or Applicant B answer “YES” to any of the following questions 1-14, that person may not be eligible for Medicare Supplement or Life Insurance coverage.**

<b>To the Best of Your Knowledge:</b>	<b>APPLICANT</b>	<b>APPLICANT B</b>
1. Are you currently hospitalized or confined to a nursing facility; or are you bedridden or confined to a wheelchair?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been diagnosed with Parkinson’s Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been diagnosed with Alzheimer’s Disease, Senile Dementia, or any other cognitive disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? If you do <b>not</b> have diabetes, this question should be answered “NO”.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you have diabetes that has ever required more than 50 units of insulin daily?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you been hospital confined three or more times in the last two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**APPLICANT** *(attach a separate sheet if needed)*

Medication Name (pharmacy label)	Date <b>Originally Prescribed</b>
Frequency and Dosage	Diagnosis/Condition

**APPLICANT B** *(attach a separate sheet if needed)*

Medication Name (pharmacy label)	Date <b>Originally Prescribed</b>
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)*


# Agent Certification

FORETHOUGHT LIFE INSURANCE COMPANY  
Administrative Office P.O. Box 14659, Clearwater, FL 33766-4659 1-877-492-5870



I the undersigned insurance agent certify;

**THAT**, I have taken an application for:

**Primary insured:**

Medicare Supplement  
Standard

Medicare Supplement  
Select

- Plan A
- Plan C
- Plan F
- Plan G
- Plan N

- Plan C
- Plan F
- Plan G
- Plan N

**Applicant B:**

Medicare Supplement  
Standard

Medicare Supplement  
Select

- Plan A
- Plan C
- Plan F
- Plan G
- Plan N

- Plan C
- Plan F
- Plan G
- Plan N

Offered by **FORETHOUGHT LIFE INSURANCE COMPANY**,

to \_\_\_\_\_  
(Applicant(s)),

**THAT**, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

**THAT**, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of

\$ \_\_\_\_\_ which has been paid to me by

- Check       ~~Money order~~       ACH (Check appropriate method of payment)

**THAT**, I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

**THAT**, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services in connection with this insurance policy being applied for.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of agent

I, the undersigned applicant, understand that I will receive a copy of this form when my policy is issued and delivered to me.

\_\_\_\_\_  
Name of agency

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Address of agent / Agency

\_\_\_\_\_  
Signature of spouse, if applying

\_\_\_\_\_  
Phone number

**Forethought Life Insurance Company**  
**PO Box 14659**  
**Clearwater, FL 33766-4659**

**Authorization to Release Confidential Medical Information**

**Records and information obtained will be disclosed to Forethought Life Insurance Company so that it can: 1) evaluate my application for insurance; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) and administer coverage.**

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, the MIB, Inc., the Veterans Administration, or other insurance companies, who has knowledge of my medical records and history to release any and all records and information to be exchanged between Forethought Life Insurance Company and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and it assigns as necessary to fulfill the purpose of this disclosure.

I hereby authorize you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, testing, treatment, or advice for the following: alcohol abuse, drug abuse, psychiatric and psychological disorders, heart disease, mental disease, pharmacy prescriptions, HIV or AIDS, sexually transmitted diseases, hepatitis, and Sickle Cell Anemia.

**I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. I understand Forethought Life Insurance Company may report information to MIB, Inc. or to other insurance companies to which I have or may apply. I understand this Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Forethought Life Insurance Company at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. I understand a photocopy of this Authorization will be treated in the same manner as the original.**

I understand that if I refuse to sign this Authorization to release complete medical records, Forethought Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

\_\_\_\_\_  
Name of Proposed Insured (please print)

\_\_\_\_\_  
Name of Proposed Insured B (please print)

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Proposed Insured B

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**Forethought® Freedom<sup>SM</sup>**  
**Final Expense Life Insurance**



Forethought® Freedom<sup>SM</sup> is a whole life insurance product designed to help cover final expenses such as the costs associated with funeral and burial expenses. The Forethought Freedom product provides guaranteed, level premiums and uses the same simplified application as the Forethought® Medicare Supplement Standard and Select Plans.

- Minimum face amount – \$2,500
- Maximum face amount – \$25,000 Level death benefit  
   \$15,000 Graded death benefit  
   \$10,000 Return of premium death benefit
- Policy is rated on age at last birthday – may backdate 6 months to save age.
- Monthly bank draft premiums are displayed on the rate chart.  
   - Other modal premiums available are quarterly, semi-annual and annual.  
   See rate chart for modal factors.
- Underwriting Classes are Smoker and Non-Smoker.  
   - A smoker is considered anyone who has smoked cigarettes in the past 12 months.
- One check for both a Medicare Supplement policy and a Forethought Freedom policy is acceptable.
- The Calculate your premium form must be completed and submitted with application.

<b>Death benefit</b>	<b>Months 1-12</b>	<b>Months 13-24</b>	<b>Months 25+</b>
Level benefit	100% of face	100% of face	100% of face
Graded benefit* (Accidental Death - 100% of face)	30% of face	70% of face	100% of face
Return of premium benefit*	110% premiums paid	110% premiums paid	100% of face

\* Not available in all states.

**Please advise your client that a phone interview will be conducted within the next few days so they will be prepared to receive the call.**

This is only a brief description of the policy guidelines. Please refer additional questions to your licensed insurance agent.

**Monthly EFT premium rates – full death benefit coverage only**

Issue Age	Female									
	Per \$1,000		\$2,500		\$5,000		\$7,500		\$10,000	
	NS	S	NS	S	NS	S	NS	S	NS	S
65	\$3.89	\$5.54	\$13.10	\$17.21	\$22.84	\$31.05	\$32.57	\$44.89	\$42.30	\$58.73
66	\$4.07	\$5.80	\$13.54	\$17.86	\$23.70	\$32.35	\$33.86	\$46.84	\$44.03	\$61.33
67	\$4.24	\$6.06	\$13.97	\$18.51	\$24.57	\$33.65	\$35.16	\$48.79	\$45.76	\$63.92
68	\$4.41	\$6.31	\$14.40	\$19.16	\$25.43	\$34.95	\$36.46	\$50.73	\$47.49	\$66.52
69	\$4.67	\$6.66	\$15.05	\$20.02	\$26.73	\$36.68	\$38.41	\$53.33	\$50.08	\$69.98
70	\$4.93	\$7.01	\$15.70	\$20.89	\$28.03	\$38.41	\$40.35	\$55.92	\$52.68	\$73.44
71	\$5.28	\$7.53	\$16.56	\$22.19	\$29.76	\$41.00	\$42.95	\$59.81	\$56.14	\$78.63
72	\$5.62	\$8.04	\$17.43	\$23.48	\$31.49	\$43.60	\$45.54	\$63.71	\$59.60	\$83.82
73	\$5.97	\$8.56	\$18.29	\$24.78	\$33.22	\$46.19	\$48.14	\$67.60	\$63.06	\$89.01
74	\$6.31	\$9.08	\$19.16	\$26.08	\$34.95	\$48.79	\$50.73	\$71.49	\$66.52	\$94.20
75	\$6.75	\$9.60	\$20.24	\$27.38	\$37.11	\$51.38	\$53.98	\$75.38	\$70.84	\$99.39
76	\$7.61	\$10.73	\$22.40	\$30.19	\$41.43	\$57.00	\$60.46	\$83.82	\$79.49	\$110.63
77	\$8.48	\$11.85	\$24.57	\$33.00	\$45.76	\$62.63	\$66.95	\$92.25	\$88.14	\$121.88
78	\$9.34	\$12.98	\$26.73	\$35.81	\$50.08	\$68.25	\$73.44	\$100.69	\$96.79	\$133.12
79	\$10.21	\$14.19	\$28.89	\$38.84	\$54.41	\$74.30	\$79.93	\$109.77	\$105.44	\$145.23
80	\$11.07	\$15.40	\$31.05	\$41.87	\$58.73	\$80.36	\$86.41	\$118.85	\$114.09	\$157.34

Issue Age	Male									
	Per \$1,000		\$2,500		\$5,000		\$7,500		\$10,000	
	NS	S	NS	S	NS	S	NS	S	NS	S
65	\$4.93	\$7.27	\$15.70	\$21.54	\$28.03	\$39.70	\$40.35	\$57.87	\$52.68	\$76.03
66	\$5.28	\$7.79	\$16.56	\$22.84	\$29.76	\$42.30	\$42.95	\$61.76	\$56.14	\$81.22
67	\$5.62	\$8.39	\$17.43	\$24.35	\$31.49	\$45.33	\$45.54	\$66.30	\$59.60	\$87.28
68	\$5.97	\$9.00	\$18.29	\$25.86	\$33.22	\$48.35	\$48.14	\$70.84	\$63.06	\$93.33
69	\$6.31	\$9.60	\$19.16	\$27.38	\$34.95	\$51.38	\$50.73	\$75.38	\$66.52	\$99.39
70	\$6.66	\$10.21	\$20.02	\$28.89	\$36.68	\$54.41	\$53.33	\$79.93	\$69.98	\$105.44
71	\$7.09	\$10.99	\$21.11	\$30.84	\$38.84	\$58.30	\$56.57	\$85.76	\$74.30	\$113.23
72	\$7.53	\$11.76	\$22.19	\$32.78	\$41.00	\$62.19	\$59.81	\$91.60	\$78.63	\$121.01
73	\$8.04	\$12.54	\$23.48	\$34.73	\$43.60	\$66.09	\$63.71	\$97.44	\$83.82	\$128.80
74	\$8.56	\$13.49	\$24.78	\$37.11	\$46.19	\$70.84	\$67.60	\$104.58	\$89.01	\$138.31
75	\$9.17	\$14.45	\$26.30	\$39.49	\$49.22	\$75.60	\$72.14	\$111.71	\$95.06	\$147.83
76	\$10.47	\$16.18	\$29.54	\$43.81	\$55.71	\$84.25	\$81.87	\$124.69	\$108.04	\$165.13
77	\$11.76	\$17.91	\$32.78	\$48.14	\$62.19	\$92.90	\$91.60	\$137.66	\$121.01	\$182.43
78	\$13.06	\$19.64	\$36.03	\$52.46	\$68.68	\$101.55	\$101.33	\$150.64	\$133.99	\$199.73
79	\$14.36	\$21.37	\$39.27	\$56.79	\$75.17	\$110.20	\$111.07	\$163.61	\$146.96	\$217.03
80	\$15.74	\$23.10	\$42.73	\$61.11	\$82.09	\$118.85	\$121.45	\$176.59	\$160.80	\$234.33

**To estimate the monthly premium for face amounts other than \$2,500, \$5,000, \$7,500, or \$10,000, multiply the "Per \$1,000" factor by the desired face amount, divide by \$1,000 and add a \$3.37 monthly policy fee.**

**For quarterly premium mode, multiply the monthly premium by 3.01**

**For semi-annual premium mode, multiply the monthly premium by 5.95**

**For annual premium mode, multiply the monthly premium by 11.56**

# Calculate your premium

## Forethought® 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.

Steps	Example	Applicant's premium	Applicant B's premium
<b>Premium</b> Write in your Medicare Supplement Plan's premium from the Outline of Coverage table.	\$128.52		
<b>Payment Options</b> To determine other payment schedules, multiply your monthly premium by: 3 to pay four times a year (quarterly) 6 to pay twice a year (semi-annually) 12 to pay once a year (annually)	\$128.52 Monthly payment \$385.56 Quarterly payment \$771.12 Semi-annual payment \$1,542.24 Annual payment		
<b>Enrollment/Policy fee</b> There is a one-time application fee of \$25.00 <b>This will be collected with your initial payment and will NOT affect your renewal premium.</b>	\$128.52 + \$25.00 = \$153.52  Example shows initial payment (monthly schedule).		

# Calculate your premium

## Forethought® Life Insurance

### TO ADD FORETHOUGHT® FREEDOM<sup>SM</sup>

For total face amounts other than \$2,500, \$5,000, \$7,500, or \$10,000, multiply the "Per \$1,000" column by the number of units applied for and add the \$3.37 monthly policy fee to your calculation.		Applicant's premium calculation	Applicant B's premium calculation
Choose the base face amount of life insurance coverage you want to purchase (\$2,500, \$5,000, \$7,500 or \$10,000)	Base face amount \$5,000 (Example based on Male age 75 non-smoker)	Premium amount \$49.22	
Add any additional \$1,000 Face Amount increments	1 Additional \$1,000 increment x \$9.17 per \$1,000	Total additional increment premium = \$9.17	
<b>Payment Options</b> Multiply monthly premium by: 3.01 for a quarterly premium 5.95 for a semi-annual premium 11.56 for an annual premium <b>BILLING MODE MUST BE THE SAME AS THE MEDICARE SUPPLEMENT BILLING MODE</b>	\$49.22 base premium + \$9.17 additional increment \$58.39 total monthly premium for life insurance  x3.01 (Quarterly) = \$175.75 x5.95 (Semi-annual)=\$347.42 x11.56 (Annual) = \$674.99	Total life premium  \$49.22 + \$9.17 \$58.39	
Add the Medicare Supplement (from top section) and Life Insurance premiums (this section) together	\$153.52 (Med Supp) + \$58.39 (Life Ins) \$211.91	One check payable to Forethought Life Insurance Company for \$211.91	

**COMPLETE AND RETURN WITH APPLICATION**

# Medicare Supplement height and weight chart

To determine whether you may purchase coverage, locate your height, then weight in the chart below. If your weight is not in the Standard column we're sorry, you're not eligible for Medicare Supplement coverage at this time. If your weight is located in the Standard column you may proceed in completing the application.

## FORETHOUGHT® MEDICARE SUPPLEMENT

	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 +

**IMPORTANT NOTICE:  
REPLACEMENT OF LIFE INSURANCE  
OR ANNUITIES**

FORETHOUGHT LIFE INSURANCE COMPANY  
ONE FORETHOUGHT CENTER  
BATESVILLE, INDIANA 47006  
INSURANCE — 800/331-8853  
ANNUITIES — 877/244-7526

**This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.** You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?  YES  NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?  YES  NO

If you answered **“Yes”** to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

<b>INSURER NAME &amp; ADDRESS</b>	<b>CONTRACT OR POLICY #</b>	<b>INSURED OR ANNUITANT</b>	<b>REPLACED (R) OR FINANCING (F)</b>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because \_\_\_\_\_

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant’s Signature and Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Producer’s Signature and Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**I do not want this notice read aloud to me. \_\_\_\_\_ (Applicants must initial only if they do not want the notice read aloud.)**

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A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?  YES  NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?  YES  NO

If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

<b>INSURER NAME &amp; ADDRESS</b>	<b>CONTRACT OR POLICY #</b>	<b>INSURED OR ANNUITANT</b>	<b>REPLACED (R) OR FINANCING (F)</b>
---------------------------------------	---------------------------------	---------------------------------	--

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because \_\_\_\_\_

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Producer's Signature and Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**I do not want this notice read aloud to me. \_\_\_\_\_ (Applicants must initial only if they do not want the notice read aloud.)**

**LEAVE WITH APPLICANT**

## **LIFE INSURANCE AND ANNUITIES REPLACEMENT MODEL REGULATION**

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

**PREMIUMS:**            *Are they affordable?  
Could they change?  
You're older—are premiums higher for the proposed new policy?  
How long will you have to pay premiums on the new policy? On the old policy?*

**POLICY VALUES:**    *New policies usually take longer to build cash values and to pay dividends.  
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.  
What surrender charges do the policies have?  
What expense and sales charges will you pay on the new policy?  
Does the new policy provide more insurance coverage?*

**INSURABILITY:**        *If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.  
You may need a medical exam for a new policy.  
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.  
Suicide limitations may begin anew on the new coverage.*

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**  
*How are premiums for both policies being paid?  
How will the premiums on your existing policy be affected?  
Will a loan be deducted from death benefits?  
What values from the old policy are being used to pay premiums?*

**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**  
*Will you pay surrender charges on your old contract?  
What are the interest rate guarantees for the new contract?  
Have you compared the contract charges or other policy expenses?*

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**  
*What are the tax consequences of buying the new policy?  
Is this a tax free exchange? (See your tax advisor.)  
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?  
Will the existing insurer be willing to modify the old policy?  
How does the quality and financial stability of the new company compare with your existing company?*

**Forethought Life Insurance Company**  
**Administrative Office**  
**PO Box 14659 • Clearwater, FL 33766-4659**

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 insurance or Medicare Advantage and replace it with a policy to be issued by Forethought 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. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration and acceptance by the replacing insurer, you find that the 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**

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).

- |   |   |
|---|---|
| <input type="checkbox"/> Additional benefits.                       | <input type="checkbox"/> My plan has outpatient drug coverage and I am enrolling in Part D.                     |
| <input type="checkbox"/> No change in benefits, but lower premiums. | <input type="checkbox"/> Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment. |
| <input type="checkbox"/> Fewer benefits and lower premiums.         | <input type="checkbox"/> Other, (please specify) _____.   |

1. State laws provide that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

2. 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 any company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

\_\_\_\_\_  
Signature of Agent, Broker, or other Representative

\_\_\_\_\_  
PRINTED Name and Address of Issuer, Agent, or Broker

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Signature of Applicant B, if applying

\_\_\_\_\_  
Date

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**Forethought Life Insurance Company**  
**Administrative Office**  
**PO Box 14659 • Clearwater, FL 33766-4659**

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- |   |   |
|---|---|
| <input type="checkbox"/> Additional benefits.                       | <input type="checkbox"/> My plan has outpatient drug coverage and I am enrolling in Part D.                     |
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| <input type="checkbox"/> Fewer benefits and lower premiums.         | <input type="checkbox"/> Other, (please specify) _____.   |

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\_\_\_\_\_  
Signature of Agent, Broker, or other Representative

\_\_\_\_\_  
PRINTED Name and Address of Issuer, Agent, or Broker

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Signature of Applicant B, if applying

\_\_\_\_\_  
Date

**RETURN TO COMPANY**

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**Forethought Life Insurance Company**  
**PO Box 14659**  
**Clearwater, FL 33766-4659**

**INVESTIGATIVE CONSUMER REPORT NOTICE TO APPLICANT**

Federal law requires that notice of investigation be given to persons applying for insurance. In making this application for insurance to Forethought Life Insurance Company (the Company), it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living (the term "mode of living" does not relate directly or indirectly to the sexual orientation of any proposed insured). You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon proper identification, you have the right to inspect and/or receive a copy of the report from the consumer reporting agency. You have the right to make a written request to the Company within a reasonable period of time to receive additional detailed information about the nature and scope of the investigation. Write to: Underwriting Department, Forethought Life Insurance Company, P.O. Box 14659, Clearwater, Florida, 33766-6960.

**MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE**

Information regarding your insurability will be treated as confidential. Forethought Life Insurance Company (the Company) or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The Company or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**MEDICARE SUPPLEMENT / SELECT INITIAL PREMIUM RECEIPT**

MAKE CHECK PAYABLE TO: FORETHOUGHT LIFE INSURANCE COMPANY

Received from \_\_\_\_\_ (Proposed Insured) an application for a Medicare Supplement / Medicare Select Policy with Forethought Life Insurance Company (the Company), and \$ \_\_\_\_\_ for the initial premium. In the event the application is not accepted by the Company, the above amount will be refunded. No obligation is incurred by the Company unless said application is approved by the Company at its Administrative Office and a policy is issued.

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

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

\_\_\_\_\_  
Date

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# Forethought Life Insurance Company

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**Consumers choosing to have initial premiums paid through ACH (Automated Clearing House) for Medicare Supplement/Life Applications may have their initial premium automatically deducted from their checking or savings account through the Electronic Funds Transfer (EFT) process. When they do, you may fax the application and required forms instead of mailing them.**

Follow these easy steps to submit Medicare Supplement/Life Apps using ACH for the initial premium:

## **STEP 1 – COMPLETE THE AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER SECTION ON THE APPLICATION.**

Applicants wishing to pay electronically will need to complete the appropriate Medicare Supplement/Life Authorization for Electronic Funds Transfer section on the Application and include a voided check.

## **STEP 2 – FAX THE FOLLOWING ITEMS TO THE DEDICATED LINE FOR ACH PAYMENTS AT 1-855-808-0944**

- 1) ACH fax transmittal cover sheet on the back of this form
- 2) Medicare Supplement/Life Application and other required forms including authorization for EFT
- 3) Voided check for EFT

**If you fax the application, do not mail it as processing errors occur and additional charges could result in the duplication.**

For producer use only. Not for use with the general public.

THINKING AHEAD<sup>SM</sup> FORETHOUGHT<sup>®</sup>



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Forethought Life Insurance Company ("Forethought"), provides innovative insurance and financial solutions for families managing retirement and end-of-life needs. Headquartered in Indianapolis, Indiana, Forethought provides life insurance and annuities.

Forethought has been consistently recognized by A.M. Best for financial strength.

As of June 30, 2011, Forethought has assets owned and under management in excess of \$5.1 billion, approximately \$1 billion in annual revenue, more than \$4.6 billion of life insurance and annuity business in force, and has served more than 2 million policyholders since 1985.

## **Forethought Life Insurance Company**

**Administrative office**  
PO Box 14659  
Clearwater, FL 33766-4659

Phone: 1-877-492-5870

***[www.forethought.com](http://www.forethought.com)***

THINKING AHEAD<sup>SM</sup> **FORE  
THOUGHT<sup>®</sup>**