Medicare Supplement Insurance
Application Transmittal Form

Please fill out the following fields:

Selling agent name

Selling agent number

Agent telephone

Agent email

Submitting Medicare Supplement applications to Allstate Health Solutions is easy. Here's how:

1. **Download the appropriate application.** Fill it out with your client.

2. **Submit the completed application.** There are 3 ways to submit paper Medicare Supplement Insurance applications. **MAKE SURE YOU INCLUDE THIS COVER LETTER, INCLUDING YOUR INFORMATION.**

    1. **Mail:**
    Allstate Health Solutions
    PO Box 95464
    Cleveland, OH 44101

    2. **Email (scanned apps):**
    Send to NPSMedicareSuppApps@NGIC.com
    Please be sure to send securely.

    3. **Fax:**
    (888) 344-3232

For status updates and/or confirmation of receipt, call Agent Services:
(888) 966-2345 (Monday-Friday, 7:00 a.m. - 4:00 p.m. Central Time).

Allstate Health Solutions is a marketing name for products underwritten by American Heritage Life Insurance Company.

Application for Medicare Supplement Insurance

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

☐ New Business ☐ Conversion ☐ Reinstatement

Section A. Applicant Information

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

I agree to receive my certificate and any other plan documents or correspondence electronically: ☐ Yes ☐ No

Applicant's Height _____ft _____in Weight _____lbs

When last have you used tobacco in any form, or used nicotine products including a patch, gum, or electronic cigarettes?
_____/_____ (mm/yyyy) ☐ Never

Section B. Plan Information

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

Plan Applied For:

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

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

Have you lived with any of the following people, who have an active National General Accident & Health Medicare Supplement insurance policy, for the past 12 months and still live with them currently? ☐ Yes ☐ No

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

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

If Yes, what is the policy number _____

Section C. Medicare and Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. **Please include a copy of the notice from your prior insurer with your application**.

If you are between the ages of 65 and 75, you are eligible, beginning on your birthday and for 45 days after, to cancel your existing Medicare Supplement policy with us and replace it with another Medicare Supplement Policy from us with the same or less benefits. During this period, we cannot deny or condition your coverage nor discriminate in pricing because of your health status, receipt of health care or your medical condition.

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

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

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

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

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

5. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates:
   If you are still covered under this plan, leave "END" blank.
   Start____/____/____ (mm/dd/yyyy) End ____/____/____ (mm/dd/yyyy)
   (a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? (If yes, complete the Replacement Notice.) ☐ Yes ☐ No
   (b) Planned date of termination____/____/____ (mm/dd/yyyy)
   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   (d) Did you drop a Medicare Supplement or Medicare Select policy to enroll in this plan? ☐ Yes ☐ No

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

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

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

Section D. Health Information

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

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

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

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

Name: _____

Address: _____

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

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

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

Cancer

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

Cardiovascular

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

Circulatory

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

Neurological

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

Other

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

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

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

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

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

Cardiovascular

- □ Cardiomyopathy
- □ Congestive Heart Failure
- □ Enlarged Heart
- □ Heart Valve Disease or Regurgitation

Neurological

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

Autoimmune Disorder

- □ AIDS, ARC, or HIV infection
- □ Myasthenia Gravis
- □ Systemic Lupus
- □ Systemic Scleroderma

Other

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

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

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

a. Depression

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

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

Comments on medical conditions or medications-

_____

_____

_____

_____

Section E. Disclosure, Acknowledgements, and Agreement

Disclosure:

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Acknowledgments and Agreement:

I wish to apply for Medicare Supplement insurance coverage. I acknowledge that I have received or been given access to review: (a) an Outline of Coverage for the policy applied for; and (b) a “Guide to Health Insurance for People with Medicare.”

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

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

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

Applicant’s Signature: _____

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

Section F. Agent Statement

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

Send Policy to ☐ Agent ☐ Applicant

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

Name _____

Relationship to the Applicant _____

Type of assistance provided _____

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

If Yes, provide relationship:_____

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

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

I certify: 1) I have accurately recorded the information supplied by the Applicant; 2) I have given the Applicant an **Outline of Coverage** for the policy being applied for, the **Guide to Health Insurance for People on Medicare,** and the **Notice of Information Practices**; and 3) I have reviewed the current health coverage of the Applicant and have completed the chart above, as applicable. I find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.

Agent Signature: _____ Date: _____ (mm/dd/yyyy)

Agent Name: _____ Agent ID: _____

Allstate HEALTH SOLUTIONS

Billing Information

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

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

Select policy premium payment option (check only one):

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

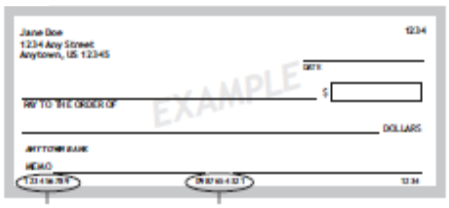
     Name on Account:_____

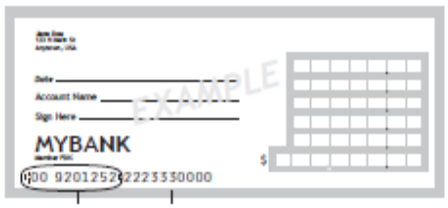
     Bank name:_____

     Routing number: __ __ __ __ __ __ __ __ __

     Account number:_____

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





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

Billing Address:

Street:_____

City: _____ State: _____ Zip code: _____

Billing Authorization

Please read the following carefully.

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

Signature of Primary Insured Date

Medicare Supplement Activity Tracker Discount Authorization Form

Please fill out the following fields:

Applicant name: _____

Applicant phone number: _____

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

Selling agent name: _____

Selling agent phone number: _____

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

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

Authorize and Agree:

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

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

Applicant signature: _____

Date: _____

AHLIC-MEDSUPP-ACTIVITY TRACKER (9/2022)

Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

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

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

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

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

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

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

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

_____ _____

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

_____ _____

Date of Birth Date

_____

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

(Return to Company)

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

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

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

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

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

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

☐ Additional benefits.

☐ No change in benefits, but lower premiums

☐ Fewer benefits and lower premiums.

☐ Change in benefits (Gaining additional benefit(s), but losing some existing benefit(s)).

☐ My plan has outpatient drug coverage and I am enrolling in Part D.

☐ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.

_____

☐ Other (please specify) _____

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

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

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

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

_____ _____
Applicant's Signature Date

AMERICAN HERITAGE LIFE INSURANCE COMPANY
1776 American Heritage Life Drive, Jacksonville, Florida 32224
Telephone 888-966-2345

Applicant's Name: _____

Policy Number: _____

Name of Existing Insurer: _____

Expiration Date of Existing Insurance: _____

SERVICE	BENEFIT	MEDICARE PAYS	EXISTING COVERAGE	SUPPLEMENT PAYS	YOU PAY
Hospital Inpatient	First 60 Days 61st to 90th Day 91st to 150th Day (Lifetime Reserve) Beyond 150 Days	All But $1632 All But $408 All But $816 Nothing			
Skilled Nursing Home Care	First 20 Days Additional 80 Days Beyond 100 Days	100% of Cost All But $204 Nothing			
Medical Expense	Physician's Services in Hospital, office or home; inpatient and outpatient medical services and supplies at a hospital; physical and speech therapy and ambulance	80% of Medicare Determined Allowable Charges After $240 Deductible			
Prescription Drugs		Inpatient Prescription Drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant.			

This policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

Date:_____ Applicant Signature: _____

Insurance Producer Signature: _____

AHLIC NHIC-IMSCH

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Definition of Eligible Person for Guaranteed Issue

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

☐ Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all such supplemental health benefits to the individual because the individual leaves the plan; or

☐ Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

☐ Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

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

☐ Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment; or

☐ Upon *first* enrolling for benefits under Part B, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months; or

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

☐ Terminated your Medicare Supplement policy with us, within 45 days following your birthday. Under this definition, if the Medicare Supplement policy you terminate is:

- Plan A or B, you are eligible from Plan A from us;
- Plan C, D, E or H, you are eligible for plans A or N from us;
- Plan G or I, you are eligible for Plans A, G or N from us
- Plan F or J (not high deductible versions), you are eligible for any plan available from us;
- Plan M or N, you are eligible for Plan N from us.

The time period in which you must apply for the plan you are eligible to receive begins on your birthday and ends 45 days thereafter. You must be between the ages of 65 and 75, and have an active Medicare Supplement policy with us to qualify. You must submit evidence of your most recent coverage along with your application for coverage.

☐ Other Guarantee Issue rights available under State law.

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

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Outline of Medicare Supplement Plans A, F, High Deductible F, G, N

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

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

	Plans Available to All Applicants								**Medicare first eligible before 2020 only**	
Benefits	**A**	**B**	**D**	**G[1]**	**K**	**L**	**M**	**N**	**C**	**F[1]**
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2024[2]					$7060[2]	$3530[2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

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

Attained Age	Female			Male		
	Preferred Select	Preferred	Standard	Preferred Select	Preferred	Standard
0-64	250.60	287.30	344.48	283.20	324.66	389.22
65	102.23		122.60	115.54		138.51
66	102.23		122.60	115.54		138.51
67	102.23	108.40	129.99	115.54	122.51	146.87
68	102.23	113.78	136.44	115.54	128.59	154.16
69	102.23	119.07	142.74	115.54	134.53	161.24
70	102.89	125.17	150.08	116.27	141.45	169.58
71	107.01	130.18	156.12	120.95	147.14	176.35
72	111.27	135.37	162.25	125.70	152.92	183.32
73	116.10	140.73	168.68	131.16	158.98	190.60
74	121.41	146.27	175.31	137.14	165.23	198.09
75	126.87	151.99	182.25	143.37	171.77	205.89
76	132.31	156.59	187.69	149.48	176.89	212.10
77	137.09	161.28	193.35	154.89	182.23	218.51
78	142.00	166.08	199.12	160.45	187.66	224.93
79	147.13	171.09	205.10	166.24	193.30	231.77
80	152.52	176.20	211.19	172.29	199.04	238.62
81	157.12	181.52	217.61	177.53	205.09	245.89
82	161.82	186.94	224.14	182.86	211.25	253.27
83	167.62	192.37	230.67	189.44	217.40	260.65
84	172.48	197.79	237.09	194.85	223.45	267.93
85	177.17	203.11	243.51	200.19	229.50	275.09
86	181.81	208.43	249.93	205.46	235.55	282.37
87	186.36	213.65	256.13	210.56	241.40	289.43
88	191.00	218.97	262.55	215.84	247.45	296.70
89	195.73	224.39	268.97	221.12	253.50	303.86
90	200.65	230.03	275.71	226.66	259.85	311.56
91	205.65	235.76	282.68	232.39	266.42	319.37
92	210.84	241.71	289.75	238.20	273.08	327.39
93	216.12	247.76	297.04	244.20	279.95	335.63
94	221.48	253.92	304.44	250.28	286.93	343.97
95	227.03	260.28	312.06	256.54	294.11	352.64
96	232.68	266.75	319.78	262.89	301.39	361.30
97	238.50	273.42	327.83	269.51	308.97	370.39
98	244.51	280.31	336.10	276.31	316.77	379.80
99+	250.60	287.30	344.48	283.20	324.66	389.22

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

Rate Calculator

Monthly Rate

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

Quarterly, Semi-Annual, or Annual Rate

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

Roommate Household Discount:	7%
Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies):	10%
Annual Pay Discount:	10%
Activity Tracker "Wearable" Discount:	5%

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

Area Factors:

Illinois Zip Codes	Factor
600-608	1.127
Rest of State	1.000

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

Attained Age	Female			Male		
	Preferred Select	Preferred	Standard	Preferred Select	Preferred	Standard
0-64	319.28	366.03	438.83	360.76	413.59	495.83
65	130.31		156.22	147.23		176.51
66	130.31		156.22	147.23		176.51
67	130.31	138.17	165.64	147.23	156.11	187.16
68	130.31	145.03	173.86	147.23	163.86	196.45
69	130.31	151.70	181.84	147.23	171.38	205.44
70	131.07	159.45	191.19	148.12	180.19	216.04
71	136.31	165.83	198.78	154.00	187.34	224.57
72	141.70	172.39	206.69	160.12	194.80	233.52
73	147.88	179.24	214.91	167.10	202.55	242.80
74	154.63	186.29	223.36	174.72	210.51	252.42
75	161.64	193.65	232.13	182.61	218.78	262.27
76	168.57	199.49	239.17	190.47	225.41	270.23
77	174.62	205.43	246.32	197.33	232.15	278.29
78	180.90	211.58	253.67	204.42	239.08	286.65
79	187.42	217.93	261.24	211.74	246.21	295.12
80	194.31	224.48	269.12	219.55	253.64	304.11
81	200.15	231.23	277.21	226.15	261.27	313.20
82	206.17	238.18	285.52	232.93	269.09	322.60
83	213.60	245.13	293.92	241.38	277.01	332.10
84	219.73	251.98	302.12	248.30	284.74	341.40
85	225.77	258.83	310.31	255.11	292.46	350.59
86	231.66	265.58	318.41	261.76	300.09	359.79
87	237.46	272.23	326.39	268.33	307.62	368.77
88	243.44	279.08	334.59	275.06	315.34	378.07
89	249.50	286.04	342.89	281.89	323.17	387.47
90	255.74	293.19	351.51	288.97	331.29	397.18
91	262.16	300.54	360.34	296.23	339.61	407.10
92	268.75	308.10	369.37	303.66	348.12	417.32
93	275.43	315.76	378.52	311.18	356.74	427.65
94	282.28	323.62	387.97	318.95	365.65	438.40
95	289.31	331.68	397.64	326.90	374.77	449.24
96	296.52	339.94	407.52	335.02	384.08	460.40
97	303.90	348.40	417.71	343.40	393.68	471.97
98	311.46	357.07	428.12	351.95	403.49	483.75
99+	319.28	366.03	438.83	360.76	413.59	495.83

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

Rate Calculator

Monthly Rate

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

Quarterly, Semi-Annual, or Annual Rate

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

Roommate Household Discount: 7%

Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies): 10%

Annual Pay Discount: 10%

Activity Tracker "Wearable" Discount: 5%

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

Area Factors:

Illinois Zip Codes	Factor
600-608	1.127
Rest of State	1.000

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan High F
Attained Age Premium Rates
Rates Effective Upon Approval

Attained Age	Female			Male		
	Preferred Select	Preferred	Standard	Preferred Select	Preferred	Standard
0-64	99.47	114.03	136.71	112.39	128.85	154.46
65	40.71		48.78	45.97		55.11
66	40.71		48.78	45.97		55.11
67	40.71	43.17	51.72	45.97	48.74	58.43
68	40.71	45.31	54.29	45.97	51.16	61.33
69	40.71	47.40	56.87	45.97	53.60	64.28
70	40.91	49.77	59.69	46.24	56.26	67.41
71	42.51	51.72	61.99	48.03	58.43	70.06
72	44.21	53.78	64.43	49.92	60.73	72.85
73	46.10	55.88	67.01	52.10	63.15	75.67
74	48.23	58.10	69.62	54.46	65.61	78.64
75	50.38	60.36	72.38	56.94	68.21	81.75
76	52.55	62.19	74.60	59.41	70.31	84.25
77	54.41	64.02	76.71	61.46	72.30	86.64
78	56.38	65.94	79.04	63.69	74.49	89.35
79	58.46	67.97	81.48	66.04	76.79	92.05
80	60.59	70.00	83.91	68.45	79.08	94.76
81	62.44	72.13	86.45	70.52	81.48	97.67
82	64.28	74.26	88.99	72.60	83.87	100.58
83	66.57	76.39	91.63	75.25	86.36	103.49
84	68.47	78.52	94.17	77.40	88.76	106.41
85	70.35	80.65	96.71	79.51	91.15	109.32
86	72.21	82.78	99.25	81.59	93.54	112.13
87	73.98	84.81	101.69	83.60	95.84	114.93
88	75.84	86.94	104.22	85.68	98.23	117.74
89	77.70	89.07	106.76	87.77	100.62	120.66
90	79.64	91.30	109.41	89.95	103.12	123.67
91	81.68	93.64	112.27	92.29	105.81	126.90
92	83.71	95.97	115.02	94.55	108.40	129.91
93	85.84	98.41	117.98	96.99	111.19	133.35
94	87.96	100.84	120.94	99.43	113.99	136.67
95	90.17	103.38	123.91	101.86	116.78	140.00
96	92.39	105.91	126.97	104.39	119.67	143.43
97	94.69	108.55	130.15	106.99	122.66	147.07
98	97.08	111.29	133.43	109.69	125.75	150.71
99+	99.47	114.03	136.71	112.39	128.85	154.46

Open Enrollment or Guaranteed Issue: *Select the lowest available rate based on age*
Underwritten: *Determine Underwriting Class based on Tobacco, HT/WT, and Preferred Select Medical Question*
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Rate Calculator

Monthly Rate

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

Quarterly, Semi-Annual, or Annual Rate

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

Roommate Household Discount: 7%

Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies): 10%

Annual Pay Discount: 10%

Activity Tracker "Wearable" Discount: 5%

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

Area Factors:

Illinois Zip Codes	Factor
600-608	1.127
Rest of State	1.000

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

Attained Age	Female			Male		
	Preferred Select	Preferred	Standard	Preferred Select	Preferred	Standard
0-64	260.98	299.19	358.73	294.91	338.10	405.37
65	106.64		127.83	120.47		144.46
66	106.64		127.83	120.47		144.46
67	106.64	113.07	135.54	120.47	127.74	153.17
68	106.64	118.69	142.26	120.47	134.08	160.77
69	106.64	124.15	148.85	120.47	140.29	168.15
70	107.23	130.45	156.41	121.18	147.42	176.73
71	111.47	135.61	162.62	125.99	153.27	183.77
72	115.86	140.95	169.03	130.95	159.30	191.02
73	120.92	146.57	175.73	136.64	165.62	198.58
74	126.47	152.37	182.64	142.87	172.14	206.35
75	132.18	158.36	189.87	149.37	178.94	214.56
76	137.87	163.16	195.63	155.80	184.38	221.08
77	142.85	168.06	201.51	161.43	189.92	227.71
78	147.97	173.07	207.49	167.20	195.56	234.45
79	153.32	178.28	213.70	173.21	201.40	241.40
80	158.93	183.60	220.12	179.57	207.45	248.67
81	163.71	189.13	226.75	184.99	213.71	256.16
82	168.59	194.77	233.50	190.49	220.07	263.86
83	174.62	200.40	240.24	197.30	226.42	271.46
84	179.67	206.03	246.99	202.99	232.78	279.05
85	184.54	211.56	253.63	208.51	239.04	286.54
86	189.36	217.09	260.26	213.96	245.29	294.02
87	194.09	222.52	266.79	219.33	251.45	301.40
88	198.92	228.05	273.43	224.79	257.70	309.00
89	203.92	233.78	280.28	230.42	264.16	316.70
90	209.02	239.62	287.25	236.15	270.72	324.51
91	214.20	245.57	294.43	242.05	277.49	332.63
92	219.57	251.73	301.83	248.13	284.47	341.09
93	225.03	257.98	309.34	254.30	291.54	349.53
94	230.67	264.45	317.06	260.65	298.82	358.20
95	236.41	271.02	324.90	267.09	306.21	367.07
96	242.32	277.81	333.06	273.80	313.90	376.27
97	248.42	284.80	341.43	280.69	321.79	385.79
98	254.61	291.89	349.92	287.67	329.79	395.42
99+	260.98	299.19	358.73	294.91	338.10	405.37

Open Enrollment or Guaranteed Issue: *Select the lowest available rate based on age*
Underwritten: *Determine Underwriting Class based on Tobacco, HT/WT, and Preferred Select Medical Question*
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Rate Calculator

Monthly Rate

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

Quarterly, Semi-Annual, or Annual Rate

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

Roommate Household Discount:	7%
Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies):	10%
Annual Pay Discount:	10%
Activity Tracker "Wearable" Discount:	5%

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

Area Factors:

Illinois Zip Codes	Factor
600-608	1.127
Rest of State	1.000

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

Attained Age	Female			Male		
	Preferred Select	Preferred	Standard	Preferred Select	Preferred	Standard
0-64	200.62	230.00	275.69	226.64	259.83	311.46
65	81.98		98.25	92.60		111.05
66	81.98		98.25	92.60		111.05
67	81.98	86.93	104.18	92.60	98.19	117.75
68	81.98	91.24	109.35	92.60	103.06	123.59
69	81.98	95.44	114.40	92.60	107.82	129.25
70	82.44	100.29	120.22	93.14	113.30	135.86
71	85.71	104.27	125.00	96.84	117.81	141.19
72	89.10	108.40	129.94	100.66	122.46	146.79
73	92.96	112.68	135.05	105.01	127.28	152.56
74	97.20	117.11	140.42	109.85	132.35	158.71
75	101.59	121.70	145.88	114.76	137.49	164.84
76	105.89	125.32	150.24	119.65	141.60	169.72
77	109.75	129.12	154.80	124.01	145.90	174.89
78	113.73	133.02	159.46	128.50	150.29	180.15
79	117.83	137.01	164.22	133.11	154.78	185.51
80	122.14	141.10	169.18	138.02	159.45	191.17
81	125.84	145.38	174.24	142.15	164.22	196.92
82	129.63	149.75	179.50	146.43	169.17	202.77
83	134.30	154.13	184.75	151.73	174.12	208.71
84	138.13	158.40	189.91	156.08	178.98	214.56
85	141.90	162.68	195.07	160.36	183.84	220.41
86	145.55	166.87	200.02	164.44	188.52	225.97
87	149.20	171.05	205.08	168.60	193.28	231.72
88	152.94	175.33	210.24	172.84	198.14	237.57
89	156.75	179.70	215.40	177.08	203.00	243.42
90	160.65	184.17	220.75	181.48	208.05	249.46
91	164.63	188.74	226.30	186.04	213.29	255.70
92	168.78	193.49	231.96	190.69	218.61	262.13
93	173.01	198.34	237.81	195.50	224.13	268.66
94	177.32	203.28	243.66	200.31	229.64	275.29
95	181.71	208.32	249.71	205.28	235.34	282.12
96	186.28	213.55	256.05	210.50	241.33	289.33
97	190.92	218.88	262.40	215.72	247.31	296.45
98	195.73	224.39	269.05	221.18	253.57	303.95
99+	200.62	230.00	275.69	226.64	259.83	311.46

Open Enrollment or Guaranteed Issue: *Select the lowest available rate based on age*
Underwritten: *Determine Underwriting Class based on Tobacco, HT/WT, and Preferred Select Medical Question*
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Rate Calculator

Monthly Rate

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

Quarterly, Semi-Annual, or Annual Rate

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

Roommate Household Discount:	7%
Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies):	10%
Annual Pay Discount:	10%
Activity Tracker "Wearable" Discount:	5%

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

Area Factors:

Illinois Zip Codes	Factor
600-608	1.127
Rest of State	1.000

PREMIUM INFORMATION
We, American Heritage Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State. We will not change the premiums for this policy during your first year of coverage. Thereafter your premium will increase each year based on your age at that time. No rate adjustment may be made on an individual basis. Also, your renewal premiums may change on a renewal date following the Effective Date of any change in the deductible and/or coinsurance amounts which you are required to pay under Medicare. Any such premium change will be based on the actuarial computations that we then use to determine the renewal premium.

HOUSEHOLD PREMIUM DISCOUNT
You are eligible for a Household Premium Discount if: (1) you reside with your spouse, who owns or is issued a Medicare supplement policy written by American Heritage Life Insurance Company, or (2) for the past year you have resided with at least one, but no more than three, other adults who are age 18 or older who own or are issued a Medicare supplement policy written by American Heritage Life Insurance Company. The discounted premium will be priced 7% lower than the rates illustrated. Your policy's household premium discount will be removed if the other adult no longer resides with you (other than in the case of his or her death).

DISCLOSURES
Use this outline to compare benefits and premiums among policies, certificates and contracts.

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 your insurance company.

RIGHT TO RETURN POLICY
If you find that you are not satisfied with your policy, you may return it to us at: 1776 American Heritage Life Drive, Jacksonville, Florida 32224. 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 payments.

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 American Heritage 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 “The Medicare Handbook” 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.

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.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$0	$1632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* 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	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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 the 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 (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 $240 of Medicare Approved Amounts**	$0	$0	$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts**	$0	$0	$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $240 of Medicare Approved Amounts**	$0	$0	$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN F and HIGH DEDUCTIBLE 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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
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	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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 the 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 and High Deductible F (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

**Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 $240 of Medicare Approved Amounts**	$0	$240 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts**	$0	$240 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $240 of Medicare Approved Amounts**	$0	$240 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Other Benefits - Not Covered by Medicare			
FOREIGN TRAVEL- NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum

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.*

*** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2800 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
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	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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 the 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 (continued)

MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

*** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2800 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 $240 of Medicare Approved Amounts**	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts**	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Parts A & B			
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $240 of Medicare Approved Amounts**	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
Other Benefits - Not Covered by Medicare			
FOREIGN TRAVEL- NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
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	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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 the 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 (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

** Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 $240 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	$0 Generally 80%	$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	$240 (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.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $240 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $240 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE - MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First $240 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $240 (Part B Deductible) $0
Other Benefits - Not Covered by Medicare			
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first60 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

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE APRIL 14, 2003

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of our Plan's customers' Protected Health Information and to provide those customers with notice of our legal duties and privacy practices with respect to your Protected Health Information. If your state provides privacy protections that are more stringent than those provided by HIPAA, we will maintain your Protected Health Information in accordance with the more stringent state standard.

This Notice applies to "Protected Health Information" associated with "Health Plans" issued by American Heritage Life Insurance Company.

This Notice describes how we may use and disclose Protected Health Information to perform claims handling, payment, general insurance operations, and for other purposes that are permitted or required by law. Use or disclosure of your Protected Health Information for the purposes described in this Notice may be made in writing, orally, or by electronic means.

We are required to abide by the terms of this Notice. However, we may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your Protected Health Information that we maintain, including any information we created or received prior to issuing the new notice. If we make a material revision to our Privacy Notice, copies will be sent to you if you are then currently insured under our Plan.

Protected Health Information means information about you that is created or received by us and during the administration of coverage under the Plan, which identifies you or for which there is a reasonable basis to believe the information can be used to identify you and that relates to:

1) the past, present or future physical or mental health condition of the individual; or
2) the provision of health care to the individual; or
3) the past, present or future payment for the provision of health care to the individual.

Uses and Disclosures of Protected Health Information With Your Written Authorization

Except as described in the next section of this Notice, we will not use or disclose your Protected Health Information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing at any time, except to the extent that we have already taken action in reliance on the authorization; or the authorization was obtained as a condition of obtaining coverage, to the extent that other law allows the insurer to contest a claim under the policy or the policy itself.

Uses and Disclosures of Protected Health Information Without Your Written Authorization

For Payment. We may make use of and disclose your Protected Health Information without your written authorization as may be necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims or certify these services are covered under your Plan.

For Plan Administrative Operations. We may make use of and disclose your Protected Health Information without your written authorization as necessary for our Plan administrative operations. Plan administrative operations include our usual business activities, examples of which are management, licensing, peer review, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, claims handling, complaint handling and other functions related to your Plan.

To Individuals Involved In Your Care. We may, without your written authorization, for the purposes of treatment, payment or Plan administrative operations, disclose the fact that you are covered under a Plan or that payment has been processed to a family member, other relative, your close personal friend or any other person you may identify. In these circumstances, we would not disclose any Protected Health Information which is not directly relevant to that person's involvement with your care or with payment for your care.

If you have designated a person to receive information regarding payment of the premium or pay premium via credit card, we may inform that person or credit card facility when your premium has not been paid or received by us.

We may also disclose limited Protected Health Information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

To Our Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these may include, but are not limited to our duly appointed insurance agents, financial auditors, reinsurers, legal services, enrollment and billing services, claim payment and medical management services. We may provide access to your Protected Health Information without your written authorization to one or more of these outside persons or organizations who assist us with payment or Plan administrative operations. We require these business associates to appropriately safeguard the privacy of your information.

To Plan Sponsors. If you are enrolled in a group health plan, we may share summary health information with your employer, union, or other employee organization that sponsors and maintains the group health plan, for purposes of obtaining premium bids; or modifying, amending, or terminating the group health plan; or enrollment and disenrollment information.

For Other Products and Services. We may contact you without your written authorization to provide information regarding Plan upgrades or additional benefits that may be of interest to you. For example, we may use the fact that you currently are insured under a Plan for the purpose of communicating to you about changes to our Plan or products that could enhance or add value to existing coverage.

For Disclosure With Authorization. Unless otherwise excluded in this notice, we will not disclose any other Protected Health Information to any person or entity not specifically mentioned elsewhere in this Notice without your express written authorization.

For Other Uses and Disclosures. We are permitted or required by law to make some other uses and disclosures of your Protected Health Information without your authorization. We may release your Protected Health Information:

- if required by law to a government authorized health oversight agency or company conducting audits, investigations, or civil or criminal proceedings.

- if required to do so by a court or administrative ordered subpoena or discovery request. In most cases you will have notice of such a release.

- for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.

- as required by law if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect or domestic violence.

- to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.

- to law enforcement officials as required by law to report wounds, injuries or crimes.

- to coroners, medical examiners and/or funeral directors consistent with law.

- for a national security or intelligence activity or, if you are a member of the military, as required by the armed forces.

- to workers' compensation agencies or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Your Rights

Right to Inspect and Copy Your Protected Health Information. You may have access to our records that contain your Protected Health Information in order to inspect and obtain copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from our Privacy Officer and submit the completed form to our Privacy Office. If you request copies, we may charge you copying and mailing costs.

Right to Amend Your Protected Health Information. You have the right to request that we amend your Protected Health Information maintained in our enrollment, payment, claims adjudication and case or medical management records, or other records we use to make decisions about you. If you desire to amend these records, please obtain an amendment request form from our Privacy Officer and submit the completed form to our Privacy Office. We will comply with your request unless special circumstances apply. If your physician or other health care provider created the information that you desire to amend, you should contact the provider to amend the information.

Right to an Accounting of the Disclosures of Your Protected Health Information. Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by us on or after April 14, 2003, excluding disclosures made earlier than six years before the date of your request. If you request an accounting more than once during any 12 month period, we will charge you a reasonable fee for the subsequent accounting statements.

Right to Request Confidential Communications. We will accommodate your reasonable request to receive communications of your Protected Health Information from us by alternative means of communication or at alternative locations if the request clearly states that disclosure of that information could endanger you.

Right to Request Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request restrictions on some of our uses and disclosures of your Protected Health Information to family members and others involved in your care or payment for care; or some of our uses and disclosures used to carry out treatment, payment, or Plan administrative operations, by notifying us of your request for a restriction in writing mailed to the contact identified at the end of this Notice. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request but will attempt to accommodate your requests. We retain the right to terminate an agreed-to restriction. In the event of a termination of an agreed-to restriction by us, we will notify you of

such termination, but the termination will only be effective for Protected Health Information we receive after we have notified you of the termination. You also have the right to terminate any agreed-to restriction by contacting us using the "Contact Information" provided at the end of this Notice.

Personal Representatives. You may exercise your rights through a personal representative who will be required to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or if you are the parent of a minor child. We reserve the right to deny access to your personal representative.

Right to Receive Paper Copy of this Notice. You may obtain a copy of this Notice. You may obtain a paper copy of this Notice even if you agreed to receive such notice electronically. Please contact us and we will mail it to you.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, send it in writing to the "Contact Information" at the address listed at the end of this Notice. There will be no retaliation for filing a complaint.

You may obtain a copy of this Notice by writing to us at the contact address below.

Contact Information

If you have questions or need further assistance regarding this Notice, you may contact:

Allstate Benefits
Attn: HIPAA Privacy Officer
1776 American Heritage Life Drive
Jacksonville, Florida 32224

Or, you may telephone the Customer Care Center at 1-800-521-3535.