WESTERN UNITED LIFE ASSURANCE COMPANY

A ManhattanLife Company

Administrative Office: P. O. Box 924408, Houston, TX 77292-4408

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

☐ **Reinstatement**

APPLICANT	**RESIDENCE ADDRESS**
Last *First* *MI*	*Street:*
Check the Medicare Supplement Plan You Prefer:	*City:*
☐ **Plan A** ☐ **Plan F**	
☐ **Plan C** ☐ **Plan G**	*State:* *Zip Code:*
☐ **Plan N**	

MEDICARE INFORMATION	**MAILING ADDRESS**
Date first enrolled in Medicare Part A:_____	*Street:*
Date first enrolled in Medicare Part B:_____	*City:*
Medicare Claim Number: _____	*State:* *Zip Code:*
(Please include Alpha Character)	

AGE	**DATE OF BIRTH**			**SEX**
	Month	*Day*	*Year*	☐ Male ☐ Female

SOCIAL SECURITY NUMBER

AREA CODE	**TELEPHONE NUMBER**

(You do not have to answer the height and weight questions during open enrollment or a guaranteed issue period.)

HEIGHT	**WEIGHT**
Feet **Inches**	**Lbs.**

Effective Date:

Mail Policy To: ☐ Agent ☐ Insured

Special Requests:

UNDERWRITING RISK CLASSIFICATION QUESTION

Have you used any form of tobacco, an electronic cigarette (e-cig), or other nicotine products in the past 12 months?

☐ Yes ☐ No

MODAL PREMIUM: $ _____

HOUSEHOLD DISCOUNT $ _____

POLICY FEE: $ 25.00

TOTAL INITIAL PREMIUM: _____

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Bank Draft ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

PART I – HEALTH QUESTIONS

YOU ARE NOT REQUIRED TO ANSWER HEALTH QUESTIONS 1-10 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD.

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-10, YOU MAY NOT BE ELIGIBLE FOR COVERAGE.

1.	Are you bedridden, confined to a wheelchair, or require the assistance of a motorized mobility device?	☐ Yes	☐ No
2.	Are you currently hospitalized, in a nursing home or assisted living facility, or have you been hospitalized three or more times in the past two years for the same or similar condition?	☐ Yes	☐ No
3.	Are you currently receiving any occupational, speech, or physical therapy?	☐ Yes	☐ No
4.	Are you currently using the services of a home healthcare agency?	☐ Yes	☐ No

PART I – HEALTH QUESTIONS CONTINUED

5. Have you been advised by a physician to have follow-up visits, surgery, medical tests, treatment, or therapy that has not been performed? ☐ Yes ☐ No
6. Is surgery, including cataracts, anticipated in the next twelve months? ☐ Yes ☐ No
7. At any time, have you been medically diagnosed with, treated for, or had any surgery for any of the following:
   a. Parkinson's disease, multiple or amyotrophic lateral sclerosis, muscular dystrophy, Alzheimer's disease, dementia, or any other cognitive disorder? ☐ Yes ☐ No
   b. Acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV) infection? ☐ Yes ☐ No
   c. Diabetes that has required more than 50 units of insulin daily, or more than two medications (insulin or oral), chronic kidney disease or insufficiency, or renal failure requiring dialysis? ☐ Yes ☐ No
   d. Emphysema, chronic obstructive pulmonary disease (COPD), or any other chronic pulmonary condition, or any other cardio-pulmonary disorder requiring oxygen? ☐ Yes ☐ No
   e. Systemic lupus, scleroderma, or myasthenia gravis? ☐ Yes ☐ No
   f. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)? ☐ Yes ☐ No
   g. Chronic hepatitis or cirrhosis? ☐ Yes ☐ No
   h. Osteoporosis with fractures? ☐ Yes ☐ No
8. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:
   a. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery, or stent replacement? ☐ Yes ☐ No
   b. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker? ☐ Yes ☐ No
   c. Alcoholism or drug abuse? ☐ Yes ☐ No
   d. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor, or therapist? ☐ Yes ☐ No
   e. Internal cancer (examples include but are not limited to breast, lung or liver cancer, etc.), leukemia, melanoma, Hodgkin's disease, or lymphoma? ☐ Yes ☐ No
   f. A stroke or transient ischemic attack (TIA)? ☐ Yes ☐ No
   g. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement? ☐ Yes ☐ No
9. Are you diabetic? ☐ Yes ☐ No
   If "Yes," do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, peripheral venous thrombotic disease, peripheral artery disease, kidney disease, kidney failure, neuropathy, stroke, congestive heart failure, any heart disorder, or high blood pressure treated with more than two medications? ☐ Yes ☐ No
10. Do you have an implanted cardiac defibrillator? ☐ Yes ☐ No

Have you taken any prescription medications within the last 24 months? If "Yes," please list all medication(s) you have taken or are currently taking. Attach an additional sheet if necessary. *Please **DO NOT** list water pill, water retention, fluid retention or blood thinner as these are not medical conditions and will require a telephone interview. ☐ Yes ☐ No

Prescription Medication Name	Date Originally Prescribed	Frequency and Dosage	*Diagnosis/Onset Date

Primary Physician Information	Telephone Number:
Physician's Address:	
Date of Last Physician's Visit:	
Reason for Visit:	

Did you turn age 65 in the last 6 months? ☐ Yes ☐ No

Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No If "Yes," what is the effective date? _____

PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

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 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 our application.

ALL QUESTIONS MUST BE ANSWERED. Please Mark Yes or No with an "X."

To the best of your knowledge:

1. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

   NOTE TO APPLICANT: If you are participating in a "Spend-Down" program and have not met your "Share of Cost," please answer "No" to this question and proceed to Question 2.

   If "Yes,"

   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No

   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No

2. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. START __/__/__ END __/__/__

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No

   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

   (d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan? ☐ Yes ☐ No

3. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

   (b) If "Yes," with which company: _____

   with which plan: _____

   and what paid-to-date do you have? _____

   (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

4. Have you had any other health insurance coverage within the past 63 days (for example, an employer welfare benefit plan, union, or individual plan)? ☐ Yes ☐ No

   (a) If "Yes," was the plan primary or secondary to Medicare? _____

   (b) Please list the plan name and reason for termination. _____

   _____

   (c) Please list the plan dates of coverage. START __/__/__ END __/__/__

   (d) Do you intend to replace the above mentioned plan with this policy? ☐ Yes ☐ No

   (e) If you qualify for Guaranteed Issue, under what situation do you qualify? _____

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

(1) You do not need more than one Medicare Supplement Insurance Policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance 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 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 suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy 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).

Initials of Proposed Insured:_____ Date:_____

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-10 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare, and you are within six months of turning age 65.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

(a) 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; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or

(b) Enrolled in a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, or the individual is 65 years of age or older and enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under §1894 of the Social Security Act, 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 (outside of the service area), the plan is terminated within the individual's service area, the organization substantially violated a material policy provision, or a materially misrepresented the plan's provisions marketing the plan to the individual; or

(c) Enrolled in a Medicare, 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

(d) You meet other exceptional conditions as the Secretary for Health and Human Services may provide; or

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

(f) Upon *first* becoming enrolled in Medicare Part B for benefits at age 65 or older, you enrolled in a Medicare Advantage plan under Part C or PACE provider and then you disenroll within 12 months; or

(g) Enrolled in Medicare Part D plan during the initial open enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare Supplement policy and submits evidence of enrollment in Medicare Part D along with the application for this policy; or

(h) Lost eligibility for health benefits under Medicaid; or

(i) The individual meets the following requirements: (i) the individual was enrolled in both the federal Medicare Program and the Texas Health Insurance Pool on December 31, 2013; and, (ii) the individual's Pool coverage terminated on or after December 31, 2013.

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

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, Inc. (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give to Western United Life Assurance Company, or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected. I understand that I am authorizing Western United Life Assurance Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by Western United Life Assurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Medical information will not be used to decline coverage if you are applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for the evaluation and the underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Western United Life Assurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Western United Life Assurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Western United Life Assurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 924408, Houston, Texas 77292-4408. I understand that such revocation will not have any effect on actions Western United Life Assurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and/or denial of insurance benefits.

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: _____ Dated: _____
(City /State) (Month/Day/Year)

Applicant's (or Authorized Representative's) Signature: _____

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other heath insurance policies or coverages sold to the Applicant which are still in force.

_____
_____
_____

2. List any other health insurance policies or coverages sold to the Applicant in the past five (5) years which are no longer in force.

_____
_____
_____

I certify that:
1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

Signature of Agent	**Printed Agent's Name**

Agent Phone No.	**Agent No.**	**% Credit**	**%**	**State ID No.**

Signature of Agent	**Printed Agent's Name**

Agent Phone No.	**Agent No.**	**% Credit**	**%**	**State ID No.**

EMAIL CONSENT AUTHORIZATION

- ❒ I give my written consent to allow Western United Life Assurance Company (Company) to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(es) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation.
- ❒ I decline to give consent to the Company to communicate with me by email. (Do not provide email addresses below)

Primary email address:_____

Secondary email address: _____

Signature:_____ Date: _____

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

AUTHORIZATION

IN FAVOR OF: **Western United Life Assurance Company**
Administrative office: **P.O. Box 924408, Houston, Texas 77292-4408**

Name of Bank Customer: _____
Insured's Name: _____
Account Number : _____ **Routing Number:** _____

Requested draft date:
_____
(Must be 1st-28th Only)
☐ **Checking**
☐ **Savings**

To (Name of Bank): _____

Address of Bank: _____

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by Western United Life Assurance Company (Company), on my account by and payable to the order of the Company for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by the Company shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by the Company. I further agree that if any such checks or other orders drawn by the Company be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor may result in forfeiture of insurance subject to the policy's 31-day grace period.

_____ | _____

Date **Signature of Depositor**

I am aware that if my application is approved, my initial premium will be drafted upon approval.

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

AUTHORIZATION

To: **The Bank above**

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor may result in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

(Attach Voided Check) **AUTHORITY TO HONOR PREMIUM CHECKS**

Western United Life Assurance Company

Medicare Supplement
Household Discount Form

Applicant name:	Applicant Social Security Number:

I, _____ certify that I meet one of the following requirements for the Household
(Applicant)
Discount. I understand that the discount is not available to an applicant who is under 65 at the time of the requested coverage effective date.

Please check a box below:

☐ The applicant is married and residing with their spouse

☐ The applicant has been residing for at least the past 12 months with someone who is 60 years or older

Date of Marriage:

Does the Household resident currently have/or are they applying for a Family Life, Western United Life, or Manhattan Life Medicare Supplement policy:
☐ YES ☐ NO If YES, please provide a Policy number.

Policy Number:

Household resident name:			
Address:	City:	State:	Zip Code:
Social Security Number:	Birthday:		
Relationship to Applicant:			

Agent/Applicant Signature:

By signing this form I acknowledge all the information is true.

_____

Agent Signature Date

_____

Applicant Signature Date

Western United Life Assurance Company
P.O. Box 924408
Houston, Texas 77092

Toll Free: 1-800-866-3400
www.wula.com
Fax: 713-583-2738

ManhattanLife SM

WESTERN UNITED LIFE ASSURANCE COMPANY
A ManhattanLife Company
Administrative Office: P.O. Box 924408 Houston, TX 77292-4408

ManhattanLife SM
Since 1850

Notice To Applicant Regarding
REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by Western United Life Assurance 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 protection 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. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under 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 reasons:

Please check only one checkbox.

- ❒ 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.

Listed below are any other health insurance policies or coverages sold to the applicant which are still in force:

Listed below are any other health insurance policies or coverages sold to the applicant in the past five (5) years which are no longer in force:

_____
Signature of Agent, Broker, or Other Representative

_____
Typed Name and Address of Agent

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

_____ _____
Applicant's Signature Date

WESTERN UNITED LIFE ASSURANCE COMPANY
A ManhattanLife Company
Administrative Office: P.O. Box 924408 Houston, TX 77292-4408

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Typed Name and Address of Agent

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_____ _____
Applicant's Signature Date