



Medicare Supplement Insurance Application Package

Alabama

CL MS-APPK 06AL

CONSTITUTION LIFE INSURANCE COMPANY

Home Office: Lake Mary, Florida Administrative Office: P. O. Box 13547, Pensacola, Florida 32591-3547 Phone: (800) 789-6364

Fair Credit Reporting Act Pre-Notification Form

Thank you for considering Constitution Life Insurance Company as your insurance carrier. Your application will be processed as quickly as possible. Public Law 91-508 requires that we advise you that an investigative consumer report may be made in connection with this application which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through personal interviews with friends, neighbors and associates. Upon written request a complete and accurate disclosure of the "nature and scope" of the report if one is made will be provided.

Note

Please return the Application Form, any Bank Draft Card or Credit Card Authorization and Replacement Form, along with your initial premium check to Constitution Life Insurance Company. The Initial Premium Receipt and Notice To Applicant remains with you.

Medical Information Bureau Disclosure Notice

The information given in your application will be treated as confidential. Constitution Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (866) 692-6901 (TTY (866) 346-3642). Constitution Life Insurance Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted.

Investigative Consumer Report Notice

In compliance with federal and state laws, this is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared. The information for the report is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. The report includes information as to your character, general reputation, personal characteristics and mode of living (the term "mode of living" does not relate directly or indirectly to the sexual orientation of any proposed insured). You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon proper identification, you have the right to inspect and/or receive a copy of the report from the consumer reporting agency. You have the right to make a written request to us within a reasonable period of time to receive additional detailed information about the nature and scope of the investigation. Write to: Underwriting Department, Constitution Life Insurance Company, P.O. Box 13547, Pensacola, Florida 32591-3547.

Initial Premium Receipt

MAKE CHECK PAYABLE TO: CONSTITUTION LIFE INSURANCE COMPANY

Received from _____ (Applicant) an application for a Policy with Constitution Life Insurance Company, Pensacola, Florida and \$ _____ for the initial premium. In the event that the application is not accepted by the Company, the above amount will be refunded. No obligation is incurred by the Company unless said application is approved by the Company at its home office and a policy is issued.

Date

Agent

CONSTITUTION LIFE INSURANCE COMPANY

Home Office: Lake Mary, Florida Administrative Office: P. O. Box 13547, Pensacola, Florida 32591-3547 Phone: (800) 789-6364

IMPORTANT NOTICE ABOUT THE POLICY OF INSURANCE FOR WHICH YOU HAVE APPLIED

**THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS.
READ THE FOLLOWING INFORMATION CAREFULLY.**

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.
5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.
6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

ACKNOWLEDGEMENT OF ARBITRATION AGREEMENT

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not accept the requirement for arbitration.

I understand that this same type of insurance may be available through an insurance company that does not require that policy related disagreements be resolved by binding arbitration.

X

Applicant

Date

Time

X

Agent

Date

Time

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NOTICE TO AGENT REGARDING COMPLETION OF THE APPLICATION PACKAGE

“RETURN TO COMPANY”

The pages that follow which are printed with “Return to Company” at the bottom are to be removed from the application package. Only those completed in the application process need be returned to the Company.

The forms included in this application package are:

- Medicare Supplement Underwriting Guide
- State approved Medicare Supplement Application
- HIPAA form
- Pre-authorized Check and Credit Card forms
- Replacement forms
- Other state specific forms
- Guaranteed Issue Application

“LEAVE WITH APPLICANT”

The remaining pages (outer shell) which are printed with “Leave with Applicant” at the bottom are to be left with the applicant.

MEDICARE SUPPLEMENT UNDERWRITING GUIDE

The underwriting guide is designed to assist our agents in selecting and properly classifying qualified applicants for Medicare Supplement coverage. It should not be interpreted as a guarantee of final underwriting action on a specific case, as on occasion additional information gathered as a result of the selection process may impact the final decision.

In addition to the information that is provided on the application as part of the selection process, each applicant will be checked in the MIB database, a Pharmaceutical database and may also be subject to a telephone interview. With this in mind, it is of critical importance that all questions be asked, that the answers be accurately recorded, and that all medications used be listed on the application.

QUALIFICATION CRITERIA

Other than Open Enrollment and Guaranteed Issue situations, to qualify for Medicare Supplement coverage each applicant:

- Must be able to answer **no** to the health questions 1 thru 7 on the application. *Any yes answer means that that applicant is not eligible for coverage and the application should not be submitted.*
- Must meet the height and weight requirements listed on the build chart that is included in this guide. *Applicants that do not meet the stated weight maximum will not be eligible for coverage.*
- Must not have taken any of the medications listed as uninsurable.

PREMIUM RATE CLASSES

Two premium rate classes are available for the applicants that satisfied the initial qualification criteria - **Tobacco and Non-Tobacco**. The underwriting criteria for each of the classes is as follows:

- **Tobacco....** a “yes” answer to the tobacco question and is taking only maintenance medications that are not included in the uninsurable list.
- **Non-Tobacco....** a “no” answer to the tobacco question and is taking maintenance medications that are not on the uninsurable list.

UNINSURABLE MEDICATIONS

The Medications that are being taken by a proposed insured are an important consideration in the underwriting process. The following lists of medications are used to treat significant health conditions/problems and are not insurable and the application should not be submitted.

The list below is not all inclusive as many of these medications have generic forms and new medications are introduced frequently. Questions, as always, should be directed to the Medicare Supplement underwriter.

A	Disipal Donepezil Dopar Doxorubicin	I	Mutamycin	S
Adriamycin Akineton Aldesleukin Alkeran Antabuse Aricept Atrane Azathioprine AZT	E	Idalycin Imuran Insulin Interferon	N	Serentil Sinemet. for Parkinson's Stelazine Symmetrel Synapton
B	Eldepryl Emcyt Ergoloid Etoposide Eulexin Exelon	K	Navane Neosar Niloric Nitroglycerin/Nitra Novatrone	T
Baclofen Bendopa Bromocriptine Bulsufan	F	Kemadrin	O	Tacrine Teslac Thioplex Thiotepa Thorazine Ticlid Triptorelin
C	Femara Floxuridine Foscavir	L	Oncovin	V
Carbidopa Clozapine Clozaril Cogentin Compazine Cytosan	G	Larodopa Letrozole Leukeran Leukin Levadopa Lioresal Lithane Lithium Lupron	P	Velban Viadur Viorex
D	H	M	Parlodel Parsidol Permax Platino Prednisone Purinethol	Z
Dantrium Diethylstilbesterol	Hexalen Hydergine Hydrea Hydroxyurea	Megace Mellaril Memantine Methadone Methotrexate Mitoxantrone Moban	Remicaide Reminyl Retrovir Rilutek Riluzole Risperdal	Zanosar Ziprasidone Zoladex Zyprexa

HEIGHT AND WEIGHT CHART

HEIGHT	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10	5'11	6'0	6'1	6'2	6'3	6'4	6'5	6'6	6'7	6'8	6'9
MINIMUM WEIGHT	87	89	90	92	94	96	98	100	102	104	108	112	116	120	122	124	126	128	130	135	140	145	150	155	160
MAXIMUM WEIGHT	180	185	195	205	215	225	235	245	255	260	270	275	280	285	290	300	310	320	325	335	340	345	350	355	360

ADDITIONAL UNDERWRITING INFORMATION

WHEN TO SUBMIT AN APPLICATION

Constitution Life's Medicare Supplement plans can be written up to 3 months prior to the proposed effective date of coverage.

EFFECTIVE DATE OF COVERAGE

The effective date of coverage will be the day the application is approved unless another date is requested.

ISSUE STATE

Constitution Life's Medicare Supplement plans can only be written by properly licensed and appointed agents in the applicant's state of residence for plans approved in that state.

REPLACEMENTS

Constitution Life does not condone the replacement of existing Medigap policies unless it is in the best interest of the applicant. When this is the case, be sure to complete the enclosed state approved replacement form. The Company will generally decline to issue any policy that replaces an in force Medigap policy issued by any company owned or controlled by parent company Universal American Financial Corp. If any such policy is issued, no commission will be paid thereon, and any commission paid in error will be subject to chargeback by the Company.

PERSONAL HISTORY INTERVIEWS

A telephone interview may be conducted by the Company to verify vital information (on application questions) necessary to properly evaluate the risk. This information is strictly for underwriting purposes only. Please make sure your applicants are aware that someone may be contacting them for this interview and note the best times to call that would be the most convenient for your applicant. There is a space on the application to note this time. When possible, we will attempt to call at the requested time.

OPEN ENROLLMENT

Open Enrollment is the first 6 months immediately following the applicant's enrollment in Medicare Part B for applicable ages 65 and older. An applicant applying for a Medigap insurance policy during an Open Enrollment is eligible for any available plan offered by the Company, without providing medical evidence of insurability.

MEDIGAP RIGHTS AND PROTECTIONS (GUARANTEED ISSUE RIGHTS)

In some situations the applicant has the right to buy a Medigap policy outside of the Medigap Open Enrollment period without providing evidence of insurability. In these situations the Guaranteed Issue application included in this app pack should be used in conjunction with the standard application, Parts I and II. In most cases the applicant must apply for a Medigap policy within 63 calendar days after the date coverage ends. When Guaranteed Issue is requested, a copy of this documentation is required before a policy will be provided on a Guaranteed Issue basis.

PRE-EXISTING CONDITION LIMITATIONS

Refer to Part V of the included application for state specific details.

CREDITABLE COVERAGE

Refer to Part IV of the included application for state specific details.

OPEN ENROLLMENT RATE, GUARANTEED ISSUE RATE, APPLICATION FEE, AND SPOUSAL DISCOUNTS

This information can be found at the bottom of the Medicare Supplement premium rate sheet.

UNDERAGE MEDICARE FOR THE DISABLED

Where required by state law, Constitution Life offers underage Medicare Supplement for the disabled. If available in your state, plan and rate information can be found on the appropriate state premium rate sheet. All states that offer underage Medicare for the disabled require a 6 month open enrollment at age 65.

RATES AND RENEWABILITY

The policy is guaranteed renewable as long as timely premium payments are made. We can only raise the premium if we do so on all like policies in the state. A premium increase may be due to a new table of rates, increase in the insured's age or a change in Medicare's benefit structure that changes the nature of the risk the Company assumed.

SUPPLEMENTAL LIFE INSURANCE OFFER

All non-open enrollment applicants who have not applied for supplemental life coverage on the Medicare Supplement application will receive with their policy an offer to purchase pre-determined amounts of life insurance without providing additional evidence of insurability. This offer is only available for a stated period of time.

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APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

PART I: APPLICANT INFORMATION

Proposed Insured	Spouse
Name:	Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone #: () Best time to call _____ AM or PM	Phone #: () Best time to call _____ AM or PM
Social Security #: - - DOB: / /	Social Security #: - - DOB: / /
Medicare #:	Medicare #:
Height: Weight: Sex: Age:	Height: Weight: Sex: Age:
Have you used tobacco within the last 12 months? YES <input type="checkbox"/> NO <input type="checkbox"/>	Have you used tobacco within the last 12 months? YES <input type="checkbox"/> NO <input type="checkbox"/>
Name & Address of family doctor:	Name & Address of family doctor:
Beneficiary:	Beneficiary:
Relationship:	Relationship:
Proposed Effective Date:	Proposed Effective Date:

PART II: COVERAGE APPLIED FOR

MEDICARE SUPPLEMENT PLAN		MEDICARE SELECT PLAN	
PROPOSED INSURED	SPOUSE	PROPOSED INSURED	SPOUSE
Plan ____	Plan ____	Plan ____	Plan ____

PART III: MEDICAL & GENERAL (A telephone interview with the applicant(s) may be conducted to verify application)

Basic Questions (Answer for both Insureds)		
<p>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. PLEASE ANSWER ALL QUESTIONS.</p>		
<p>To the best of your knowledge:</p> <p>1. Did you turn age 65 in the last 6 months?</p> <p style="margin-left: 20px;">a. Did you enroll in Medicare Part B in the last 6 months?</p> <p style="margin-left: 20px;">b. If yes, what is the effective date? Insured _____ Spouse _____</p> <p>2. Are you covered for medical assistance through the state Medicaid program?</p> <p style="margin-left: 20px;">(If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.)</p> <p style="margin-left: 20px;">If Yes,</p> <p style="margin-left: 20px;">a. Will Medicaid pay your premiums for this Medicare supplement policy?</p> <p style="margin-left: 20px;">b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?</p>	<p>Proposed Insured</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Spouse</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><i>Part III questions continue on next page</i></p>		

PART III: MEDICAL & GENERAL (A telephone interview with the applicant(s) may be conducted to verify application)

Basic Questions (Answer for both Insureds) *Continued from previous page*

	Proposed Insured	Spouse
<p>To the best of your knowledge:</p> <p>3. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. Insured: START ___/___/___ END ___/___/___ Spouse: START ___/___/___ END ___/___/___</p>		
<p>b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>c. Was this your first time in this type of Medicare plan?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>d. Did you drop a Medicare supplement policy to enroll in the Medicare plan?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. a. Do you have another Medicare supplement policy in force?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>b. If so, with what company? Insured: _____ Spouse: _____</p>		
<p>c. What plan do you have? Insured: _____ Spouse: _____</p>		
<p>d. If so, do you intend to replace your current Medicare supplement policy with this policy? ...</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>a. If so, with what company? Insured: _____ Spouse: _____</p>		
<p>b. What kind of policy? Insured: _____ Spouse: _____</p>		
<p>c. What are your dates of coverage under the other policy? Insured: START ___/___/___ END ___/___/___ Spouse: START ___/___/___ END ___/___/___</p>		
<p>(If you are still covered under the other policy, leave "END" blank.)</p>		

Health Questions (Answer for both Insureds)	Proposed Insured	Spouse
<p>Do not answer questions 1-8 if you are applying for this coverage within 6 months of obtaining Medicare Part B, or under guaranteed issue status.</p>		
<p>IF THE ANSWER TO ANY OF QUESTIONS 1-7 IS "YES" FOR EITHER APPLICANT, THEN THAT APPLICANT IS NOT ELIGIBLE FOR COVERAGE AND HIS OR HER APPLICATION SHOULD NOT BE SUBMITTED.</p>		
<p>1. Is any person to be insured currently hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, received home health care in the past 90 days; or has any such care been medically advised?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. Has any person to be insured been diagnosed, treated or been advised by a physician that they have Alzheimer's Disease, Senile Dementia, Organic Brain Disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Parkinson's Disease, Muscular Dystrophy or paralysis?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Has any person to be insured tested positive for exposure to the HIV infection or been diagnosed and advised by a physician that they have Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. Has any person to be insured been diagnosed with Diabetes requiring the use of Insulin, Kidney Disease requiring dialysis, received or is awaiting an organ transplant?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH QUESTIONS (ANSWER FOR BOTH PROPOSED INSUREDS) *Continued from previous page*

<p>5. Within the past two years has any person to be insured had, been treated for or been advised by a physician to have treatment for:</p> <p>a. Congestive Heart Failure, Heart Attack, Angina (chest pain), Coronary Artery Disease, Cardiomyopathy, Stroke (CVA), Transient Ischemic Attack (TIA), Heart Rhythm Disorders requiring pacemaker or defibrillator?</p> <p>b. Heart or circulatory surgery of any type including Angioplasty, Bypass, Stent Placement or a Valve Replacement?</p> <p>c. Cancer (except skin cancer), Melanoma, Hodgkin’s Disease or Leukemia?</p> <p>d. Mental or Nervous Disorder requiring Psychiatric care, Alcohol or Drug Abuse (prescription or non-prescription), Cirrhosis of the Liver or Hepatitis C?</p> <p>e. Disabling/Crippling Arthritis, Osteoporosis with compression fractures, Degenerative Bone Disease, Systemic Lupus, or any other Connective Tissue Disease?</p> <p>f. Emphysema, Chronic Obstructive Pulmonary or Lung Disease, or use of Oxygen?</p> <p>6. Has any person to be insured been hospitalized two or more times within the past 24 months?</p> <p>7. Has any person to be insured been advised to have surgery, medical tests or treatment that has not been performed or have they had medical test(s) for which they have not received the results? . .</p> <p>8. Has any person to be insured taken any prescription medications within the past 12 months? . . If yes provide details (attach a separate sheet if necessary):</p>	<p>Proposed Insured</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Spouse</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Proposed Insured	Spouse	Medication	Dosage	List Condition & Reason for Medication	How long
<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>				

PART IV - CREDITABLE COVERAGE DETERMINATION

Within the last 63 days, have you been or were you covered under creditable coverage*?

Proposed Insured: Yes No Spouse: Yes No

If “yes”, what type of coverage? Insured: _____ Spouse: _____

If “yes”, with what company? Insured: _____ Policy No.: _____

Spouse: _____ Policy No.: _____

*“Creditable Coverage” means (a) a group health plan; (b) health insurance coverage; (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare); (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928; (e) Chapter 55 of Title 10 (CHAMPUS); (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under chapter 89 of Title 5 (Federal Employees Health Benefits Program); (i) a public health plan (as defined in federal regulation); or (j) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)). Creditable Coverage does not include hospital indemnity, specified disease or illness, accident or disability income plans.

PART V - INSURED CERTIFICATION

You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy will be suspended 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, substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. 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 reinstated if requested within 90 days of losing your employer or union-based group health plan.

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).

To the best of my knowledge and belief, all of the answers to the above questions 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 and the full first premium has been paid; (b) this policy has a pre-existing condition limitation. A pre-existing condition means a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage. No coverage will be provided for a pre-existing condition until 6 months after the policy has been issued. All other conditions are covered from the date the policy is issued; and (c) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that he realized 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.

Authorization: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, The Medical Information Bureau, Pharmaceutical Database, other organization, institution or person, that has any records or knowledge of me, or my health, to give Constitution Life Insurance Company or its reinsurer(s) any such information. A photographic copy of this authorization shall be as valid as the original. **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.**

I acknowledge receiving: (a) "A Guide to Health Insurance for People With Medicare"; (b) Outline of Coverage; (c) Investigative Consumer Report Notice; (d) Medical Information Bureau (MIB) Disclosure Notice; and (e) Arbitration Agreement Notice.

Signed at _____ Date _____
(City) (State) (Month/ Day) (Year)

X _____ X _____
(Applicant's Signature) (Spouse's Signature if applying for coverage)

PART VI - AGENT CERTIFICATION

The undersigned Agent certifies that the Applicant(s) has read, or had read to him/her, the completed application and that the Applicant(s) realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. AGENT COMPLETES (attach separate sheet, if necessary.)

TO AGENT: List all Health Insurance Policies sold to the applicant(s) which are still in force.

COMPANY _____ TYPE _____

List all Health Insurance Policies sold to the applicant(s) within the past 5 years which are no longer in force.

COMPANY _____ TYPE _____

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

X _____ % _____
 Licensed Agent's Signature Agent's Code Print Agent's Name Agent's State Identification

X _____ % _____
 Secondary Agent's Signature Secondary Agent Code Secondary Agent Print Name Secondary Agent Identification

Send Policy to: Agent Insured

SUPPLEMENT TO APPLICATION CL-MS-APP (1/06) AL

PLEASE PRINT

Proposed Insured _____ Spouse _____
 (if applying for coverage) (if applying for coverage)

Beneficiary _____ Beneficiary _____

Relationship _____ Relationship _____

Automatic Premium Loan Yes No Automatic Premium Loan Yes No

If you are in open enrollment or eligible for guaranteed issue for a Medicare Supplement/Select policy and are applying for life insurance, you must answer questions 1 through 8 on this application.

Issue ages 65-79 Primary Insured - Face Amount \$2,500 \$5,000 \$7,500 \$10,000 _____*
 Spouse - Face Amount \$2,500 \$5,000 \$7,500 \$10,000 _____*

* Amount must be between \$2,500 and \$10,000.

Is any insurance applied for intended to replace any life insurance or annuity currently in force? PROPOSED INSURED SPOUSE
 Yes No Yes No

If "Yes" complete and attach the appropriate replacement forms (if applicable).

Proposed Insured: _____ Company _____ Policy Number _____

Spouse: _____ Company _____ Policy Number _____

I hereby apply for life insurance as shown above based on my attached application. The answers are, to the best of my knowledge and belief, true. I agree any policy shall not be effective until it has actually been issued.

Date: _____ Signature of Proposed Insured: X _____
 (if applying for coverage)

Date: _____ Signature of Spouse: X _____
 (if applying for coverage)

PREMIUM MODE:		PREMIUM EXCLUDING				TOTAL PREMIUM	
DIRECT	CREDIT CARD	POLICY FEE		POLICY FEE		COLLECTED	
<input type="checkbox"/> Annual	<input type="checkbox"/> Annual	Insured	Spouse	Insured	Spouse	Insured	Spouse
<input type="checkbox"/> Semi Annual	<input type="checkbox"/> Semi Annual	Medicare Supplement	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Quarterly	<input type="checkbox"/> Quarterly	Life Insurance	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Monthly PAC	<input type="checkbox"/> Monthly	TOTAL AMOUNT COLLECTED				\$ _____	\$ _____

CONSTITUTION LIFE INSURANCE COMPANY

Home Office: Lake Mary, Florida Administrative Office: P. O. Box 13547, Pensacola, Florida 32591-3547 Phone: (800) 789-6364

BANK CHECK PREMIUM PAYMENT PLAN

Authorization to Honor Drafts Drawn by

CONSTITUTION LIFE INSURANCE COMPANY

To: _____

City & State: _____

Bank Transit & Routing: _____

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn on my account by and payable to the order of Constitution Life Insurance Company, Pensacola, Florida, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check 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.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date _____ X _____
Your Signature **EXACTLY** as it appears on Bank Records

Account Number

CLPAC 1/06

PRE-AUTHORIZATION FORM For Recurring Payment with Credit Card

I authorize Constitution Life Insurance Company to keep my signature on file and to charge my
 MASTERCARD VISA CARD account, on an ongoing basis, for amounts I owe.

I understand that this authorization is valid from the date indicated below unless I cancel the authorization through written notice. I also agree to contact Constitution Life Insurance Company if there are any changes to my credit card account information.

Cardholder Name

Cardholder Billing Address

City State Zip

Account Number Expiration Date

X _____
Cardholder Signature Date

CLCCAF 1/06

RETURN TO COMPANY

CONSTITUTION LIFE INSURANCE COMPANY

Home Office: Lake Mary, Florida Administrative Office: P. O. Box 13547, Pensacola, Florida 32591-3547 Phone: (800) 789-6364

IMPORTANT NOTICE ABOUT THE POLICY OF INSURANCE FOR WHICH YOU HAVE APPLIED

**THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS.
READ THE FOLLOWING INFORMATION CAREFULLY.**

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.
5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.
6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

ACKNOWLEDGEMENT OF ARBITRATION AGREEMENT

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not accept the requirement for arbitration.

I understand that this same type of insurance may be available through an insurance company that does not require that policy related disagreements be resolved by binding arbitration.

X

Applicant

Date

Time

X

Agent

Date

Time

CONSTITUTION LIFE INSURANCE COMPANY

Home Office: Lake Mary, Florida Administrative Office: P. O. Box 13547, Pensacola, Florida 32591-3547 Phone: (800) 789-6364

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

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Constitution 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 the purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY INSURER, 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.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.
- Other. (Please Specify) _____

1. Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. 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.

X

Signature of Agent, Broker or other Representative

PRINTED Name and Address of Issuer, Agent, or Broker

X

Applicant's Signature

X

Signature of Spouse, if applying

Date

CONSTITUTION LIFE INSURANCE COMPANY

Home Office: Lake Mary, Florida Administrative Office: P. O. Box 13547, Pensacola, Florida 32591-3547 Phone: (800) 789-6364

DESCRIPTION OF BENEFITS MEDICARE SUPPLEMENT SELECT POLICY

Description of Medicare Supplement Select Program. Medicare Select Policies include restricted network provisions. You must use Hospitals which participate in a network program to receive full Medicare Supplement benefits.

Reduced benefits are payable if you are treated outside the Participating Hospital network. This means you will be responsible for paying the initial Part A Deductible amount if you are admitted outside the Participating Hospital Network.

Payment for covered expenses will not be restricted if you are admitted for emergency care, are admitted outside the service area and require urgently needed services, or the services you require are not available at a participating hospital. We reserve the right to determine and verify the non-availability of such services.

Medicare Select Outline of Coverage. Refer to the attached Outline of Coverage for a summary of benefits and premium rates. Use the Outline of Coverage to compare coverage and premiums with other Medicare Supplement policies or certificates offered by us and other companies.

Participating Hospital Network. The attached list includes names, addresses and phone numbers of our Participating Providers. Our Participating Providers are available twenty-four (24) hours per day, seven (7) days per week.

Quality Assurance Program. All Hospitals within the network are approved for reimbursement of Medicare benefits. They must also comply with the criteria set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHCO).

Grievance Procedure. We have a customer service program which can provide information to you, handle your complaints and help satisfy your concerns. This grievance procedure is intended to provide an opportunity for you and us to achieve mutual agreement for the settlement of disputes that have not been settled through our customer service program or that you desire to have settled by means of a written grievance. The following procedures are aimed at achieving mutual agreement for the settlement of disputes.

CMS-S DOB

Continued on Reverse Side

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ACKNOWLEDGEMENT

I acknowledge receipt of the provisions, restrictions and limitations of the Medicare Supplement Select Program as outlined in this MEDICARE SUPPLEMENT SELECT POLICY DESCRIPTION OF BENEFITS.

X _____
Signature of Proposed Insured

Date

X _____
Signature of Spouse, if applying

Date

CONSTITUTION LIFE INSURANCE COMPANY

Home Office: Lake Mary, Florida Administrative Office: P. O. Box 13547, Pensacola, Florida 32591-3547 Phone: (800) 789-6364

MEDICARE SUPPLEMENT GUARANTEED ISSUE DETERMINATION APPLICATION COMPLETE ONLY IF APPLYING FOR A MEDICARE SUPPLEMENT POLICY ON A GUARANTEED ISSUE BASIS

For any applicant to be considered eligible for a Medicare Supplement policy on a guaranteed issue basis, *other than during an open enrollment period*, the following information and appropriate documentation must be provided in addition to completion of the application for Medicare Supplement insurance.

If you are issued a Medicare Supplement policy on a guaranteed issue basis we will waive any pre-existing condition limitation.

Prior Coverage - Employee Welfare Benefit Plan

Within the last 63 days, did your employee welfare benefit plan terminate or cease to provide all benefits supplementing Medicare?

Proposed Insured: [] Yes [] No Spouse: [] Yes [] No

If you answer "yes", you are eligible for Medicare Supplement Plans A, B, C or F on a guaranteed issue basis.

Prior Coverage – Enrolled in a Medicare Advantage (formerly Medicare+Choice) Plan or With a PACE Provider That Had Been Elected Upon First Becoming Enrolled for Benefits Under Medicare Part A

Within the last 63 days, did you terminate enrollment from a Medicare Advantage (formerly Medicare+Choice) plan or a Program of All-Inclusive Care for the Elderly (PACE), having enrolled in such plan upon first becoming enrolled for benefits under Medicare Part A, and subsequently disenrolled within 12 months of enrollment?

Proposed Insured: [] Yes [] No Spouse: [] Yes [] No

If you answer "yes", you are eligible for any Medicare Supplement policy offered by the company on a guaranteed issue basis.

Prior Coverage - First time Enrollment in Medicare Select Policy, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan, Medicare Advantage (formerly Medicare+Choice) Plan, or with a PACE Provider After Termination of Medicare Supplement Coverage

1. Within the last 12 months, did you terminate Medicare Supplement coverage to enroll for the first time in a Medicare Select Plan, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan, Medicare Advantage (formerly Medicare+Choice) Plan, or a Program of All-Inclusive Care for the Elderly (PACE)?

Proposed Insured: [] Yes [] No Spouse: [] Yes [] No

If "yes", with what Company? _____ Policy No. _____

2. Within the past 63 days, did you terminate enrollment in such plan?

Proposed Insured: [] Yes [] No Spouse: [] Yes [] No

If you answer "yes" to questions 1. and 2., you are eligible for the same Medicare Supplement plan, on a guaranteed issue basis, that you had prior to the election of the coverage that most recently terminated. However, application must be made to the same insurer that provided the Medicare Supplement coverage. If that insurer does not have that plan available, then you are eligible for a Medicare Supplement Plan A, B, C or F from this company on a guaranteed issue basis.

Company: _____ Policy Number: _____

Prior Coverage - Medicare Select Policy, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan, Medicare Advantage (formerly Medicare+Choice) Plan, or You Are 65 Years of Age or Older and Enrolled With a PACE Provider

Within the last 63 days, did you discontinue enrollment in a Medicare Select policy, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan, Medicare Advantage (formerly Medicare+Choice) Plan, or you are 65 years of age or older and discontinued enrollment in a Program of All-Inclusive Care for the Elderly (PACE) because:

a. the plan's certification was terminated or the plan was discontinued in the area in which you live?

Proposed Insured: [] Yes [] No Spouse: [] Yes [] No

b. you changed your place of residence or there was another change in circumstance (other than nonpayment of premium) which made you ineligible for the plan?

Proposed Insured: [] Yes [] No Spouse: [] Yes [] No

c. you have satisfactorily demonstrated that the organization substantially violated a material provision of the plan with respect to your care?

Proposed Insured: [] Yes [] No Spouse: [] Yes [] No

d. you have satisfactorily demonstrated that the organization, agent or other entity acting on the plan's behalf, materially misrepresented the plan's provision in the marketing of the plan to you?

Proposed Insured: [] Yes [] No Spouse: [] Yes [] No

If you answer "yes" to any questions a.- d., you are eligible for Medicare Supplement Plans A, B, C or F on a guaranteed issue basis.

Prior Coverage - Medicare Supplement Policy

Within the last 63 days, did your Medicare Supplement policy terminate because:

- a. the insurer went bankrupt, became insolvent, or involuntarily terminated the plan and there is no state law or regulation for continuation or conversion of such coverage?
Proposed Insured: [] Yes [] No Spouse: [] Yes [] No
- b. you have satisfactorily demonstrated that the insurer substantially violated a material provision of the policy with respect to your care?
Proposed Insured: [] Yes [] No Spouse: [] Yes [] No
- c. you have satisfactorily demonstrated that the insurer, agent or entity acting on the company's behalf materially misrepresented the policy's provisions in marketing the plan to you?
Proposed Insured: [] Yes [] No Spouse: [] Yes [] No

If you answer "yes" to any question you are eligible for Medicare Supplement Plans A, B, C or F on a guaranteed issue basis.

Prior Coverage – Medicare Supplement Policy with Outpatient Prescription Drug Benefits

Did you enroll in a Medicare Part D plan during the initial enrollment period (November 15, 2005 to May 15, 2006), and at the time were you enrolled under a Medicare supplement policy that covers outpatient prescription drugs?

Proposed Insured: [] Yes [] No Spouse: [] Yes [] No

Effective date of your coverage under Medicare Part D: Proposed Insured: _____ Spouse: _____
(The guaranteed issue period ends 63 days after the effective date of your coverage under Medicare Part D.)

Did you subsequently terminate your Medicare supplement policy?

Proposed Insured: [] Yes [] No Spouse: [] Yes [] No

If you answer "yes" to both questions, you are eligible for Medicare Supplement Plans A, B, C or F on a guaranteed issue basis.

If you are eligible for a Medicare Supplement policy on a guaranteed issue basis, you must provide appropriate documentation of your termination of or disenrollment from coverage or Medicare Part D enrollment along with your application for the Medicare Supplement policy. Appropriate documentation includes written information that identifies the plan of coverage, the date of the termination of or disenrollment from coverage and the reason for termination.

To the best of my knowledge and belief, the information provided above is true and correct. I understand that this application will become part of my application for coverage, and thus part of the policy. The company may investigate my responses to the questions, and the documentation that I have provided.

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.

Signed at: _____ Date: _____
City State

Signature: X _____ Signature: X _____
Proposed Insured Spouse, if applying for coverage

Signature: X _____ Agent's Code: _____
Licensed Agent

Print Agent's Name: _____ Agent's State Ins. Lic #: _____

Date: _____

CONSTITUTION LIFE INSURANCE COMPANY

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DESCRIPTION OF BENEFITS MEDICARE SUPPLEMENT SELECT POLICY

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Reduced benefits are payable if you are treated outside the Participating Hospital network. This means you will be responsible for paying the initial Part A Deductible amount if you are admitted outside the Participating Hospital Network.

Payment for covered expenses will not be restricted if you are admitted for emergency care, are admitted outside the service area and require urgently needed services, or the services you require are not available at a participating hospital. We reserve the right to determine and verify the non-availability of such services.

Medicare Select Outline of Coverage. Refer to the attached Outline of Coverage for a summary of benefits and premium rates. Use the Outline of Coverage to compare coverage and premiums with other Medicare Supplement policies or certificates offered by us and other companies.

Participating Hospital Network. The attached list includes names, addresses and phone numbers of our Participating Providers. Our Participating Providers are available twenty-four (24) hours per day, seven (7) days per week.

Quality Assurance Program. All Hospitals within the network are approved for reimbursement of Medicare benefits. They must also comply with the criteria set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHCO).

Grievance Procedure. We have a customer service program which can provide information to you, handle your complaints and help satisfy your concerns. This grievance procedure is intended to provide an opportunity for you and us to achieve mutual agreement for the settlement of disputes that have not been settled through our customer service program or that you desire to have settled by means of a written grievance. The following procedures are aimed at achieving mutual agreement for the settlement of disputes.

CMS-S DOB

Continued on Reverse Side

.....
ACKNOWLEDGEMENT

I acknowledge receipt of the provisions, restrictions and limitations of the Medicare Supplement Select Program as outlined in this MEDICARE SUPPLEMENT SELECT POLICY DESCRIPTION OF BENEFITS.

X _____
Signature of Proposed Insured

Date

X _____
Signature of Spouse, if applying

Date

All grievances:

- Must be presented in written form to Constitution Life Insurance Company, c/o Grievance Appeal Manager, 411 N. Baylen Street, Pensacola, Florida 32502.
- Must contain the words “THIS IS A GRIEVANCE” or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to the grievance procedure.
- Will be processed within 60 days after it is received by us. If a grievance is found to be valid, corrective action will be taken promptly. All concerned parties will be notified about the result of the grievance.
- Must be filed within 1 year from the date of the occurrence of the cause of the grievance.

If you are still not satisfied after your grievance is reviewed and settled, you have the right to appeal to the Department of Insurance in your state or you may request arbitration. Arbitration must be conducted in accordance with the provisions of the applicable state statute.

If we request a personal meeting with you, we will schedule this meeting at a location or in a manner which is convenient for you and does not necessitate excessive travel or undue hardship.

Conversion. If you decide not to participate in our Participating Provider Network, you may convert your Medicare Supplement Select policy to any Medicare Supplement policy offered by us which has comparable or lesser benefits and which does not contain a restricted network provision. You will not have to provide evidence of insurability if your current policy has been in force for more than 90 days.

Continuation. In the event state regulators determine that Medicare Supplement Select policies issued should be discontinued due to either the failure of the Medicare Select Program to be re-authorized or its substantial amendment, we shall continue your coverage for a period of one year from the date we are notified of such discontinuance. Following the one year period, your Medicare Supplement Select policy is converted to a Medicare Supplement policy offered by us which has comparable or lesser benefits and which does not contain a restricted network provision.

Purchase Of Other Medicare Supplement Policies or Certificates. You have the right to purchase any other Medicare Supplement Policy or Certificate offered for sale by us in your state.

CONSTITUTION LIFE INSURANCE COMPANY

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

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Constitution 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 the purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY INSURER, 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.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.
- Other. (Please Specify) _____

1. Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. 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.

X

Signature of Agent, Broker or other Representative

PRINTED Name and Address of Issuer, Agent, or Broker

X

Applicant's Signature

X

Signature of Spouse, if applying

Date

WHY CONSTITUTION LIFE?

Constitution Life Insurance Company is a leading provider of senior insurance products, including supplemental health insurance, life insurance and asset accumulation products. We are dedicated to helping America's seniors protect themselves and their families with products that offer flexibility and value, and are backed by exceptional service.

Founded in 1929, Constitution Life is today part of the Universal American Financial Corp. family of companies.

Innovative Insurance Products*:

Medicare Supplement

Medicare Select

Final Expense

Annuities

Senior Dental

Acute Care

Asset Enhancer II

*Product availability and benefits may vary by state.

Ask your Agent for information about any of our quality products.



Administrative Offices:

P.O. Box 13547

Pensacola, Florida 32591-3547

800-789-6364

www.constitutionlife.com

Your Constitution Life Agent _____

Address _____

Phone number _____