Heartland National Application Packet

Thank you for your interest in the Heartland National Medicare Supplement plan!

This application packet provides you with access to a printable copy of the Enrollment Form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by secure upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Heartland National. You may upload, email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) Download Policy Outline (.pdf) Download Application (.pdf)

Our website: http://www.medicare-texas.net

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Heartland National Life Insurance Company
PO Box 2878, Salt Lake City, UT 84110-2878
Enrollment Form - Group Medicare Supplement Insurance

☐ New Business
☐ Coverage Change

Part I – Personal Information

Group Name: Senior Savers Association

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other _______

Last Name ______________________ First Name ______________________ MI _____

Birthdate (mm/dd/yyyy) ______________ Social Security Number ______________ Age _______ Height __ ft __ in Weight _____ lbs Gender ☐ Male ☐ Female

Medicare ID Number ______________________

Street Address ____

City ______________________ State _____ Zip ______________

Best Time to Call (3 hour interval)_____ to _____ Weekend Calls Yes ☐ No ☐

Daytime Phone ______________________ Evening Phone ______________________

Cell Phone ______________________ E-Mail Address ______________________

Part II – Plan Selection

Plan Applied For:

☐ A ☐ F ☐ G ☐ N

Tobacco Use:
Have you used any tobacco products, including cigarettes, cigars, chewing tobacco or a pipe, in the past 12 months?
☐ Yes ☐ No

Part III – Eligibility

State law allows a 6 month open enrollment period beginning with the first day of the first month in which you are enrolled in Medicare Part B.

If you are under age 65 and eligible for Medicare due to disability, you may apply for and receive Plan A from us. If you are 65 or older, you may apply for and receive any Medicare Supplement Plan available from us.

Yes No

☐ ☐ 1) Are you covered under Medicare Part A?
a) If YES, what is your Part A effective date? _____/_____/_____
b) If NO, what is your eligibility date? _____/_____/_____

☐ ☐ 2) Are you covered under Medicare Part B?
a) If YES, what is your Part B effective date? _____/_____/_____
b) If NO, what is your eligibility date? _____/_____/_____

☐ ☐ 3) Did you turn 65 in the last 6 months?

Part IV – Medicare & Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare Supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with this Enrollment Form. *Please mark "Yes" or "No" below with an "X", to the best of your knowledge.*

PLEASE ANSWER ALL QUESTIONS

Yes No

☐ ☐ 1) Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility).

☐ ☐ 2) Are you covered for Medical Assistance through the state Medicaid program?

NOTE TO ENROLLEE: If you are participating in a "Spend Down Program" and have not met your "Share of the Cost", please answer "NO" to this question.

If "Yes",

☐ ☐ a) Will Medicaid pay your premiums for this Medicare Supplement certificate?

☐ ☐ b) Do you receive any benefits from Medicaid, OTHER THAN payments toward your Part B premium?

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 *"Effective"* and *"Paid-to"* dates below.
If you are still covered under this plan, leave *"Paid to"* blank.

Effective _____/_____/_____ Paid to _____/_____/_____ (mm/dd/yyyy)

☐ ☐ b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement certificate? (If "Yes" complete Replacement Notice.)
If so with which company? ____________________

Company Address: ____________________

☐ ☐ c) Was this your first time in this type of Medicare Plan?

☐ ☐ d) Did you drop a Medicare Supplement policy or certificate to enroll in the Medicare Plan?

☐ ☐ 4) a) Do you have another Medicare Supplement policy or certificate in force?

b) If so with which company? ____________________

Company Address: ____________________

What plan do you have?____________________

☐ ☐ c) If so, do you intend to replace your current Medicare Supplement policy or certificate with this certificate?
(If "Yes" complete Replacement Notice.)

☐ ☐ 5) Have you had coverage under any other health insurance within the past 63 days?
(for example, an employer, union, or individual plan)

a) If so, with what company? ____________________

What kind of policy? ____________________

b) What are your dates of coverage under the other policy?

Effective _____/_____/_____ Paid to _____/_____/_____ (mm/dd/yyyy)

Part V – General Information

1) You do not need more than one Medicare Supplement policy or certificate.

2) If you purchase this certificate, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy or certificate.

4) If, after purchasing this certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement certificate can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. Upon receipt of your request, we will return to you that portion of the premium attributable to the period of your Medicaid eligibility, subject to an adjustment for paid claims. If you are no longer entitled to Medicaid, your suspended Medicare Supplement certificate or, if that is no longer available, a substantially equivalent certificate will be reinstituted, effective as of the date of termination of Medicaid, if requested within 90 days of losing your Medicaid eligibility. If the Medicare Supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

5) If you are eligible for, and have enrolled in a Medicare Supplement policy or certificate by reason of disability and you later become covered by an employer or union based group health plan, the benefits and premiums under your Medicare Supplement policy or certificate can be suspended, if requested, while you are covered under the employer or union based group health plan. If you suspend your Medicare Supplement policy or certificate under these circumstances, and later lose your employer or union based group health plan, your suspended Medicare Supplement policy or certificate or, if that is no longer available, a substantially equivalent policy or certificate, will be reinstituted if requested within 90 days of losing your employer or union based group health plan. If the Medicare Supplement policy or certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy or certificate was suspended, the reinstituted policy or certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid Program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low Income Medicare Beneficiary (SLMB).

Part VI – Guarantee Issue Eligibility

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-15 on pages 5 and 6 of this application if (a) you are within six months of purchase 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:

- 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; *(eligible for Plans A or F*); 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, a material misrepresentation was made to the individual, or the individual meets such other exceptional conditions as the Secretary may provide *(eligible for Plans A or F)*; 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 *(eligible for Plans A or F)*; or
- Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation *(eligible for Plans A or F);* 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 *(eligible for the same Plan certificate you terminated with us, or, if that Plan is no longer available, Plans A or F);* or

Part VI – Guarantee Issue Eligibility *(continued)*

- Upon first becoming enrolled for benefits under Part B at age 65 or older, enrolled in a Medicare Advantage plan under part C or Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and then disenrolls from the plan or program by or not later than twelve (12) months after the effective date of enrollment *(eligible for all plans available from us)*; or
- Enrolled in a Medicare Part D Plan during the initial 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 a policy *(eligible for Plans A or F)*; or
- Lost eligibility for health benefits under Medicaid.

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

Part VII – Household Premium Discount Information

Does at least one but no more than three other adults reside with you in your home? Yes ❒ No ❒
If Yes, provide the following for one of the other adults:

Last Name	First Name	Social Security Number
______________________	______________________	______________________

Relationship to Enrollee ____

Part VIII – Premium Payment & Administration

Initial Premium ____________

Association Dues: (+) ____________

For _____ Months

Certificate fee: (+) $25

Total Amount Submitted: (=) ____________

Requested Effective Date (*if other than Enrollment Form Date)*

________________ (mm-dd-yyyy)

Select Bank Draft Day ________ (1st -28th)

(must be on or prior to the certificate effective date)

☐ I authorize Bank Draft Payments

☐ Draft Initial Amount ☐ Draft Immediately ☐ Draft Initial Premium On (Date) ____________

RENEWAL: ☐ Direct Bill ☐ Bank Draft (Account Type: ☐ Checking ☐ Savings)

PREMIUM Mode**:** ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Bank Draft

Bank Routing # (9 digits) ______________________________

Bank Account # (do not include check #) ______________________________

Bank Name: ____

Name(s) of Depositor(s): ______________________________________

If paying premium by Bank Draft, please include a voided check. The first draft will occur on the date your enrollment form is approved by Heartland National Life (unless specified otherwise).

Part IX – Medical Questions

Do not answer health questions 1-15 if you are in an open enrollment or guaranteed issue period. Please see pages 3-4 for an explanation of open enrollment/guaranteed issue period information.

NOTICE TO APPLICANT: Please answer all of the following questions. Please verify the accuracy and completeness of the medical information on this application. Incomplete or false information on this application could jeopardize future claims. If you answer YES to any of the following questions 1-14, you are not eligible for coverage.

1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? Yes ❒ No ❒
2. Have you been diagnosed with emphysema, chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disorders? Yes ❒ No ❒
3. Have you been diagnosed with Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with fractures, cirrhosis or kidney disease requiring dialysis? Yes ❒ No ❒
4. Have you been diagnosed with Alzheimer's disease, senile dementia, or any other cognitive disorder? Yes ❒ No ❒
5. Have you been diagnosed with or treated by a physician or licensed medical professional for acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)? Yes ❒ No ❒
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), or kidney disease? If you do **not** have diabetes this question should be answered **"NO".** Yes ❒ No ❒
7. Do you have diabetes that has ever required more than 50 units of insulin daily? Yes ❒ No ❒
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? Yes ❒ No ❒
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA or heart rhythm disorders)? Yes ❒ No ❒
10. Within the past two years have you been treated for degenerative bone disease, crippling / disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes ❒ No ❒
11. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts? Yes ❒ No ❒
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes ❒ No ❒
13. Have you been hospital confined three or more times in the last two years? Yes ❒ No ❒
14. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes ❒ No ❒

Part IX – Medical Questions *(continued)*

15. Are you taking or have you taken any prescription or over-the-counter medications within the past 24 months? If YES, please list the drug(s) below along with the date prescribed, dosage / frequency and diagnosis/medical condition for **each** medication. Attach a separate sheet if needed. Yes ❐ No ❐

Medication Name (copy of pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

Medication Name (copy of pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

Medication Name (copy of pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
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Diagnosis / Medical Condition	

Medication Name (copy of pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

Medication Name (copy of pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

PRIMARY CARE PHYSICIAN INFORMATION

Physician's Name: ____

Telephone Number: ____

Part XI – Agreement & Acknowledgement

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

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this Enrollment Form. 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 coverage applied for will not take effect until issued by the Company, and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the coverage.

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Signed at (City and State): ____________________ Date: ☐☐-☐☐-☐☐☐☐

Enrollee's Signature: ____________________ Send certificate to: ☐ Enrollee ☐ Producer

Producer's Signature: ____________________ Producer Number: 5040460

Producer Phone: 800.884.2343

Producer Supplement

All questions must be completed.

Yes	No	
☐	☐	1. Did you meet with the Enrollee in person?
☐	☐	2. Did you complete this Enrollment Form over the phone?
		3. State the name and relationship of any other person present when this Enrollment Form was taken. Name ____________ Relationship to Enrollee ____________
☐	☐	4. Did you review the Enrollment Form for correctness and any omissions?
☐	☐	5. Did the Enrollee review the Enrollment Form for correctness and any omissions?
☐	☐	6. Are you related to the Proposed Enrollee? If Yes, provide relationship: ____________

Listed below are all other health insurance policies or certificates I have (a) sold to the Enrollee which are still in force; and (b) sold to the Enrollee 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

Producer #1 Name (please print) Producer # 5040460 Split %

Producer #2 Name (please print) Producer # Split %

Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Heartland National Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Heartland National Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Heartland National Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and 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 Heartland National Life Insurance 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 Heartland National Life Insurance 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 Heartland National Life Insurance Company in writing at their Medicare Supplement Administrative Office: [P.O. Box 2878, Salt Lake City UT]. I understand that such revocation will not have any effect on actions Heartland National Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for thirty (30) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

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: Heartland at PO Box 2878, Salt Lake City, Utah 84110-2878, 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 Heartland 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, Heartland 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

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

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
Home Office: Indianapolis, Indiana 46280
Medicare Supplement Administrative Office: P. O. Box 2878, Salt Lake City, UT 84110-2878

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 Heartland National 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.

____________________________	Tiffany Jackson, PO Box 26540, Eugene, OR 97402
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

Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Heartland National Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Heartland National Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Heartland National Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and 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 Heartland National Life Insurance 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 Heartland National Life Insurance 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 Heartland National Life Insurance Company in writing at their Medicare Supplement Administrative Office: [P.O. Box 2878, Salt Lake City UT]. I understand that such revocation will not have any effect on actions Heartland National Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for thirty (30) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

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______________________________	______________________________
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)

H-HHA (13-MS)

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

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
Home Office: Indianapolis, Indiana 46280
Medicare Supplement Administrative Office: P. O. Box 2878, Salt Lake City, UT 84110-2878

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 Heartland National 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.

____________________	Tiffany Jackson, PO Box 26540, Eugene, OR 97402
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

MSREPL2010

RECEIPT

All premium checks must be payable to: **Heartland National Life Insurance Company**.
Do not make checks payable to the agent or leave the Payee blank.
EFFECTIVE DATE will be the date of the application or the date of approval.

Received from____

the sum of $ _________________________________ **dollars for** ____________**months premium, with application.** If for any reason the application is not approved and the policy is not issued, this premium is to be refunded. No liability is created or assumed by the Company, except for refund of this premium, until the policy applied for has been issued.

Date Receipt and Outline of Coverage was prepared_____________________________________

By (Agent's Signature)____

Senior Savers Association Membership Application

I hereby request enrollment as a member of Senior Savers Association and understand that the dues for standard membership are $2.00 monthly; if participating in a sponsored program, then my monthly dues may be collected with my insurance premiums. I also understand that my membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or discounts.

- PLEASE PRINT -

First Name ______________________ **M.I.** ________ **Last Name** ______________________

Address ____

City ______________________ **State** ________ **Zip** ______________________

Phone *(Home)* ______________________ *(Business)* ______________________

E-mail ______________________

I agree to comply with the By-Laws of the Association during my membership enrollment and during the term of my membership in the Association.

Signature ______________________ **Date** ______________________