Equitable National Application Packet

Thank you for your interest in the Equitable National Life 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 Equitable Life. You may 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 Coverage Outline (.pdf) Download Application (.pdf)

Our website: https://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.

Equitable National Life Insurance Company, Inc.
Administrative Office: PO Box 2730, Salt Lake City, UT 84110-2730
Application - Medicare Supplement Insurance

☐ New Business ☐ Reinstatement
☐ Coverage Change

EQUITABLE NATIONAL
LIFE INSURANCE COMPANY

Part I - Personal Information

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

Last Name | First Name | MI

Birthdate (mm/dd/yyyy) | Social Security Number | Age | Height | Weight | Gender

___ ft ___ in | _____ lbs | ☐ 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

Federal law allows a 6 month open enrollment period with the first day of the first month in which an applicant is both: (1) age 65 or older; and (2) enrolled in Medicare Part B. If you are a qualified open enrollee, 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? _____/_____/_____

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 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 this Application. *Please mark "Yes" or "No" below with an "X", to the best of your knowledge.*

PLEASE ANSWER ALL QUESTIONS

Yes	No		
☐	☐	1)	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? _____/_____/_____
☐	☐	2)	Did you turn 65 in the last 6 months?
☐	☐	3)	Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility).
☐	☐	4)	Are you covered for Medical Assistance through the state Medicaid program?
			NOTE TO APPLICANT: If you are participating in a "Spend Down Program" and have not met your "Share of the Cost", please answer "NO" to this question. If "Yes",
☐	☐		a) Will Medicaid pay your premiums for this Medicare Supplement policy?
☐	☐		b) Do you receive any benefits from Medicaid, OTHER THAN payments toward your Part B premium?
		5)	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 policy? (If "Yes" complete Replacement Notice.)
			If so, with what company? _____
			Company Address: _____
☐	☐		c) Was this your first time in this type of Medicare Plan?
☐	☐		d) Did you drop a Medicare Supplement policy to enroll in the Medicare Plan?
☐	☐	6)	a) Do you have another Medicare Supplement policy in force?
			b) If so, with what company? _____
			Company Address: _____
			What plan do you have? _____
☐	☐		c) If so, do you intend to replace your current Medicare Supplement policy with this policy? (If "Yes" complete Replacement Notice.)
☐	☐	7)	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 policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

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

4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. 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 policy or, if that is no longer available, a substantially equivalent policy 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 policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

5) If you are eligible for, and have enrolled in a Medicare Supplement policy 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

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 provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual (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, or a material misrepresentation was made to the individual (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 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 eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months (eligible for all plans available from us); or

☐ Enrolled in a Medicare Part D Plan during the initial Part D enrollment period while enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and terminate the Medicare Supplement policy (eligible for Plans A or F); or

☐ Enrolled under medical assistance under Title XIX of the Social Security Act (Medicaid), and your Medicaid coverage is involuntarily terminated (eligible for Plans A or F).

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

Part VII – Household Premium Discount Information

Policy Discount: ☐ Yes ☐ No

Are there one but no more than three adults who are age 18 and older living in the home? ☐ Yes ☐ No

Name of one other adult in the home _____ Social Security Number _____

Part VIII – Premium Payment & Administration

Initial Premium: _____

For _____ Months

Application Fee: (+) $20

Total Amount Submitted: **(=)** _____

Requested Effective Date (if other than Application Date)

_____ (mm-dd-yyyy)

Select Bank Draft Day _____ (1st -28th)
(*must be on or prior to the application 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 application is approved by Equitable National (unless specified otherwise).

All checks will be processed as EFT (Electronic Funds Transfer) from your bank.

Part IX - Medical Questions

Complete this section by checking “Yes” or “No” for each question. For applicants who are applying as an Open Enrollee or meet guarantee issue requirements, these questions need not be answered. For all other applicants, if an answer to any part of questions 1–11 is “Yes”, a policy will not be issued.

Yes	No		
☐	☐	1.	Are you dependent on a wheelchair or any motorized mobility device?
☐	☐	2.	Do any of the following apply to you? Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy
		3.	At any time, have you been medically diagnosed, treated or had surgery for any of the following?
☐	☐		A. congestive heart failure, unoperated aneurysm, defibrillator
☐	☐		B. leukemia, lymphoma, multiple myeloma, cirrhosis
☐	☐		C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy
☐	☐		D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease
☐	☐		E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant
☐	☐		F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV)
		4.	Do you have diabetes?
☐	☐		A. that required use of insulin
☐	☐		B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage
☐	☐		C. with history of heart attack or stroke (at any time)
☐	☐		D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar
		5.	Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?
☐	☐		A. alcoholism, drug abuse
☐	☐		B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder
☐	☐		C. internal cancer, melanoma, Hodgkin's Disease
☐	☐		D. hepatitis, disorder of the pancreas
		6.	Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?
☐	☐		A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease
☐	☐		B. myasthenia gravis, systemic lupus or connective tissue disorder
☐	☐		C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living
☐	☐		D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder
☐	☐		E. any lung or respiratory disorder and currently use tobacco products
☐	☐	7.	Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or any surgery that has not been performed?
☐	☐	8.	Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?
☐	☐	9.	Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving injections?
		10.	Within the past 12 months, do any of the following apply to you?
☐	☐		A. had a pacemaker implanted
☐	☐		B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer
☐	☐		C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer
☐	☐		D. had a seizure
☐	☐	11.	Was your last blood pressure reading higher than 175 Systolic or higher than 100 Diastolic?

Part X - Medical History

For applicants who are applying as an Open Enrollee or meet guarantee issue requirements, these questions need not be answered.

Yes ☐ No ☐ 1. Within the past 24 months have you been medically diagnosed, treated or had surgery for any brain, mental or nervous disorder? Provide reason and diagnosis:

_____

_____

☐ ☐ 2. Within the past 5 years have you been hospitalized, treated at an outpatient facility or emergency room for any reason?

_____

_____

List ALL prescription medications taken at any time in the past 2 years.
(use additional sheets if necessary)

Prescription Name & Dosage	Reason Taking	Date Last Used (mm/yy)

Part XI - Physician Information

For applicants who are applying as an Open Enrollee or meet guarantee issue requirements, these questions need not be answered.

DOCTOR YOU USUALLY CONSULT - Your Primary Care Physician

Name: _____ Address: _____

City, State, Zip: _____ Phone: _____

Any Specialist you have seen within the past 24 months

Name: _____ Specialty: _____

Reason for seeing (diagnosis): _____

Name: _____ Specialty: _____

Reason for seeing (diagnosis): _____

Name: _____ Specialty: _____

Reason for seeing (diagnosis): _____

Part XII – Agreement & Acknowledgement

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

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

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

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

Signed at (City and State): _____ Date: _____

Applicant's Signature: _____ Send Policy to: ☐ Applicant ☐ Producer

Producer's Signature: _____ Producer Number: 9101046540

Producer's Phone: 800.884.2343

Part XIII - Producer Supplement

Yes	No	All questions must be completed
☐	☐	1. Did you meet with the Applicant in person?
☐	☐	2. Did you complete this Application over the phone?
		3. State the name and relationship of any other person present when this application was taken.
		Name: _____ Relationship to Applicant: _____
☐	☐	4. Did you review the Application for correctness and any omissions?
☐	☐	5. Did the Applicant review the application for correctness and any omissions?
☐	☐	6. Are you related to Applicant?
		If "Yes", provide relationship: _____

Listed below are all other health insurance policies or certificates (a) sold to the Applicant which are still in force; and (b) sold to the applicant in the last 5 years which are no longer in force:

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

Producer #1 Name	Producer Number	Split %
Dann Loewenthal	9101046540	
Producer #2 Name	**Producer Number**	**Split %**

Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

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

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

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

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

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to: **Equitable National at PO Box 2730, Salt Lake City, Utah 84110-2730, 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 Equitable National 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, Equitable National 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)

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

EQUITABLE NATIONAL LIFE INSURANCE COMPANY
PO Box 2730, Salt Lake City, UT 84110-2730

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 Equitable 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. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new contract.

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

_____ Same benefits but lower premium.

_____ Fewer benefits and lower premiums.

_____ 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) _____

I call to your attention the following items for your consideration:

(1) **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that 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 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.

_____ Dann Loewenthal - PO Box 26540, Eugene, OR 97402

Producer's Signature — Producer's PRINTED Name and Address

_____ _____

Applicant's Signature — Date

Producer: If this replacement notice is necessary, have the insured complete and sign this form and leave it with the Applicant.

Replaced Company Name: _____

Replaced Company Address: _____

Return to Company

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

EQUITABLE NATIONAL LIFE INSURANCE COMPANY
PO Box 2730, Salt Lake City, UT 84110-2730

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 Equitable 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. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new contract.

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

_____ Same benefits but lower premium.

_____ Fewer benefits and lower premiums.

_____ 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) _____

I call to your attention the following items for your consideration:

(1) **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that 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 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.

_____ Dann Loewenthal - PO Box 26540, Eugene, OR 97402

Producer's Signature — Producer's PRINTED Name and Address

_____ _____

Applicant's Signature — Date

Producer: If this replacement notice is necessary, have the insured complete and sign this form and leave it with the Applicant.

Replaced Company Name: _____

Replaced Company Address: _____

Receipt

Receipt

Please Note: All premium checks must be made payable to Equitable National Life Insurance Company.
Do not make checks payable to the insurance agent or leave the payee line blank.

Received from _____ the sum of $ _____ for _____ months premium, with this 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 _____, 20 _____

by _____

Agent's Signature

Equitable National Life Insurance Company, PO Box 2730, Salt Lake City, UT 84110-2730