Part VIII – Medical Questions

If this is an Open Enrollment or Guaranteed Issue application, DO NOT answer questions 1-16 in this section.

NOTICE TO APPLICANT: Please answer all 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 1-15, you are not eligible for coverage.

1. Are you currently hospitalized, in a nursing home or assisted living facility, confined to a bed, a wheelchair or any motorized device? Yes ☐ No ☐
2. Have you been diagnosed by a licensed medical professional with emphysema, chronic obstructive pulmonary disease (COPD), cardiopulmonary disorder requiring oxygen or other chronic pulmonary disorders? Yes ☐ No ☐
3. Have you been diagnosed by a licensed medical professional with cerebral palsy, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, scleroderma, Huntington's disease, cirrhosis or chronic hepatitis? Yes ☐ No ☐
4. Have you been diagnosed by a licensed medical professional with Parkinson's disease, Alzheimer's disease, senile dementia, or any other cognitive disorder? Yes ☐ No ☐
5. Have you ever tested positive for the Human Immunodeficiency Virus (HIV) infection or been diagnosed by a medical professional, acting within the scope of his/her license, as having acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) caused by the HIV infection or other sickness or conditions derived from such infection? Yes ☐ No ☐
6. Have you been advised by a licensed medical professional that surgery may be required within 12 months for cataracts? Yes ☐ No ☐
7. Have you been advised by a licensed medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed? Yes ☐ No ☐
8. Have you been hospital confined three or more times in the last two years? Yes ☐ No ☐
9. Have you had an organ or stem cell transplant or been advised by a licensed medical professional to have an organ or stem cell transplant (excluding cornea implants)? Yes ☐ No ☐
10. Have you been diagnosed with or treated by a licensed medical professional for chronic kidney disease, kidney failure, or kidney disease requiring dialysis? Yes ☐ No ☐
11. Do you have osteoporosis, and as a result, experienced a fracture? Yes ☐ No ☐
12. Do you have diabetes that has ever required more than 50 units of insulin daily or do you have diabetes in addition to the following: neuropathy, retinopathy, peripheral venous thrombotic disease, peripheral artery disease, any heart disorder, stroke, transient ischemic attack (TIA), or kidney disease? **If you do not have diabetes, this question should be answered "No".** Yes ☐ No ☐
13. Do you have diabetes with high blood pressure and have you:
    a. Taken more than two medications for either condition (insulin dependent or oral medications)? Yes ☐ No ☐
    b. Have there been any changes in your medications within the past two years? **If you do not have diabetes this question should be answered "No".** Yes ☐ No ☐
14. Within the past two years, have you been treated for or been advised by a licensed medical professional to have treatment for:
    a. Heart attack, coronary artery disease, angina, cardiac angioplasty, bypass surgery, enlarged heart or stent placement? Yes ☐ No ☐
    b. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, any heart or valve disorder, atrial fibrillation, other heart rhythm disorder or implantation of a pacemaker? Yes ☐ No ☐
    c. Peripheral artery disease, peripheral vascular disease, peripheral venous thrombotic disease, vascular angioplasty, carotid artery disease, endarterectomy, stroke or transient ischemic attack (TIA)? Yes ☐ No ☐
    d. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement? Yes ☐ No ☐
    e. Treatment for internal cancer, leukemia, lymphoma, multiple myeloma, melanoma, alcoholism, substance use disorder, any mental or nervous disorder requiring treatment (including hospital confinement), psychiatric care, or have you had any amputation caused by disease? Yes ☐ No ☐
15. Do you have an implanted cardiac defibrillator? Yes ☐ No ☐

SUPREME COUNCIL OF THE ROYAL ARCANUM
AN INTERNATIONAL FRATERNITY PROVIDING FAMILY PROTECTION

Supreme Council of the Royal Arcanum
Administrative Office: PO Box 13770, Oklahoma City, OK 73113

☐ **New Business** ☐ **Reinstatement**
☐ **Coverage Change** **Certificate #:**_____

MEDICARE SUPPLEMENT INSURANCE APPLICATION

Part I – Personal Information

Gender	Last Name	First Name	MI	Date of Birth
☐ M ☐ F	•	•	•	/ /
Age	**Social Security No.**	**Medicare ID No.**	**Height**	**Weight**
•	•	•	•	•

Address
•

City | State | Zip Code
• | • | •

Mailing Address (if different than residential address)
•

City | State | Zip Code
• | • | •

Daytime Phone Number | Cell Phone Number | E-Mail Address
• | • | •

Have you used any tobacco products, including cigarettes, cigars, chewing tobacco, a pipe, electronic cigarette (e-cig) or other nicotine product in the past 12 months? Yes ☐ No ☐

Part II – Plan Selection

Plan Applied For:
☐ A ☐ D ☐ F* ☐ N

Requested Effective Date
_____/_____/_____ *(mm/dd/yyyy)*

Plan F is available **ONLY to those first eligible for Medicare before 1/1/2020.*

Part III – Eligibility

To the best of your knowledge:

1. Are you covered under Medicare Part A? Yes ☐ No ☐
   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? Yes ☐ No ☐
   a) If YES, what is your Part B effective date: _____/_____/_____
   b) If NO, what is your eligibility date: _____/_____/_____
3. Did you turn age 65 in the last 6 months? Yes ☐ No ☐

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 certificate, or that you had certain rights to buy such a 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 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 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 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 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 the 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/certificate to enroll in the Medicare Plan?

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

b) If so, with which company? _____ Paid to _____/_____/_____

Company Address: _____

What plan do you have: _____

☐ ☐ c) If so, do you intend to replace your current Medicare Supplement policy/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 which company? _____

What kind of policy/certificate? _____

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

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

Part V – General Information

1. You do not need more than one Medicare Supplement 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 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. 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 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 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 certificate under these circumstances, and later lose your employer or union based group health plan, your suspended Medicare Supplement certificate or, if that is no longer available, a substantially equivalent certificate, will be reinstituted if requested within 90 days of losing your employer or union based group health plan. 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.
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 – Household Premium Discount Information

You may be eligible for a certificate with a lower premium rate based on your answers to the questions in this section.

1. Do you currently live with your spouse, including validly recognized civil union and domestic partners, who owns or is issued a Medicare supplement certificate written by Royal Arcanum or do you currently have a household resident (at least one, no more than three) with whom you have continuously resided for the last 12 months and at least one owns or is issued a Medicare supplement certificate with Royal Arcanum? Yes ☐ No ☐

2. If you answered "YES" to question 1 above, please fill out the following information about the household resident:

   Name (First/Middle/Last): _____

   Relationship to Applicant: _____

Part VII – Premium Payment & Administration

Initial Premium: $ _____

Monthly Fraternal Dues: (+) $ 1.00

Certificate Fee*: (+) $ 25.00

Total Premium: (=) $ _____ Draft Initial Premium On (Date) ____/____/____

Total Payment with Application: $ _____ Select Bank Draft Day _____ (1st – 28th)

*This one-time fee will be refunded, along with your premium, if the certificate is not issued or you return it during your 30-day free look.

PREMIUM MODE: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Bank Draft

☐ I authorize Bank Draft Payments

Account Type: ☐ Checking ☐ Savings

Bank Routing # (9 digits)

•

Bank Account # (do not include check #)

•

Bank Name

•

Name(s) of Depositor(s)

•

The first draft will occur on the date your Application is approved by the Company (unless specified otherwise). The Company will draft premiums due in the mode and from the account identified above for the life of the certificate unless instructed in writing to do otherwise.

Please attach a voided check, if available.

Part VIII – Medical Questions (continued)

16. 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 off pharmacy label) •

Date Originally Prescribed / /

Dosage and Frequency •

Diagnosis/Medical Condition •

Medication Name (copy off pharmacy label) •

Date Originally Prescribed / /

Dosage and Frequency •

Diagnosis/Medical Condition •

Medication Name (copy off pharmacy label) •

Date Originally Prescribed / /

Dosage and Frequency •

Diagnosis/Medical Condition •

Medication Name (copy off pharmacy label) •

Date Originally Prescribed / /

Dosage and Frequency •

Diagnosis/Medical Condition •

Medication Name (copy off pharmacy label) •

Date Originally Prescribed / /

Dosage and Frequency •

Diagnosis/Medical Condition •

Medication Name (copy off pharmacy label) •

Date Originally Prescribed / /

Dosage and Frequency •

Diagnosis/Medical Condition •

PRIMARY CARE PHYSICIAN INFORMATION

Physician’s Name: ______________________ Telephone Number: ______________

Part IX – 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 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 certificate benefits 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 certificate.

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

ROYAL ARCANUM, AN INTERNATIONAL FRATERNITY IS LICENSED TO DO BUSINESS IN THE STATE OF ILLINOIS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN THE ILLINOIS LIFE AND HEALTH GUARANTY ASSOCIATION (OTHERWISE KNOWN AS THE GUARANTY ASSOCIATION). THIS MEANS THAT FRATERNAL BENEFIT SOCIETIES CANNOT BE ASSESSED FOR THE INSOLVENCY OF OTHER LIFE INSURERS OR OTHER FRATERNAL BENEFIT SOCIETIES. BY LAW, A FRATERNAL BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OWN SOLVENCY. IF THERE IS AN IMPAIRMENT OF RESERVES, A CERTIFICATE HOLDER MAY BE ASSESSED A PROPORTIONATE SHARE OF THE IMPAIRMENT.

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

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

Producer's Signature _____ Producer Number: _____

Producer's Phone: _____

Part X – Explanation of Benefits Delivery Agreement & Acknowledgement

By checking "Yes", I elect electronic delivery of all contractual, regulatory and administrative correspondence regarding my Medicare supplement certificate, to include claim correspondence, Explanations of Benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will receive communications at the last email address I provided.

☐ **Yes** ☐ **No**

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 9.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my certificate, free of charge, by calling toll-free: 1-833-585-0550; or by writing to: Customer Care Center, Supreme Council of the Royal Arcanum, PO Box 13770, Oklahoma City, OK 73113.

Applicant's Signature: _____ Date: _____

Producer's Signature: _____ Producer Number: _____

Part XI – 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 I have (a) sold to the Applicant which are still in force; and (b) sold to the applicant in the last 5 years which are no longer in force:

Company	Type of Policy/Certificate	Effective Date	In Force
•	•	/ /	☐ Yes ☐ No
•	•	/ /	☐ Yes ☐ No
•	•	/ /	☐ Yes ☐ No

Producer #1 Name (please print)	Producer Number	Split %
•	•	•
Producer #2 Name (please print)	**Producer Number**	**Split %**
•	•	•

Part XII – Producer Comments

List any additional comments or information below.

Applicant Name (please print) _____

Producer's Signature: _____

Medicare Supplement Premium Calculation Worksheet			
	Steps	**Example** (Rate displayed below is used for calculation purposes only)	**Applicant**
#1	**Age** List your age at the time of signing the application. **Zip Code** List your Zip Code used to determine your rate.	65 61826	
# 2	**Premium** Write in your Med Supp plan's premium from the Outline of Coverage provided, based on your age and Zip Code listed in Step 1.	$126.81	
# 3	**Household Premium Discount (if Applicable)** Please refer to the Underwriting Guide for specific household discount rules. **If the rules apply,** multiply the premium amount in Step 2 by .93. **If the rules do not apply, skip this step**	$126.81 x .93 = $117.93	
# 4	**Fraternal Membership Dues** There will be a $1.00 per month added to your initial and renewal premiums as membership dues.	$117.93 + 1.00 = $118.93 monthly payment	
# 5	**Payment Options** To determine other payment schedules, multiply your monthly premium (including the $1.00 monthly Fraternal Membership Dues) by: 3 - to pay 4 times a year (Quarterly) 6 - to pay twice a year (Semi-Annual) 12 - to pay once a year (Annually)	$118.93 x 3 = $356.79 Quarterly payment $118.93 x 6 = $713.58 Semi-Annual payment $118.93 x 12 = $1,427.16 Annual payment	
# 6	**Policy Fee** There is a one-time application fee of $25.00 **This will be collected with your initial payment and will NOT affect your renewal premium amount.**	$118.93 + 25.00 = $143.93 Initial payment	

Please complete and return with the application

SUPREME COUNCIL OF THE ROYAL ARCANUM
AN INTERNATIONAL FRATERNITY PROVIDING FAMILY PROTECTION
Medicare Supplement Administrative Office
PO Box 13770, Oklahoma City, OK 73113

HEALTH INFORMATION AUTHORIZATION
APPLICANT / INSURED DECLARATIONS

- This is a HIPAA required authorization.
- Please read these statements carefully.
- Print clearly using blue or black ink.
- Applicant / Insured must submit a completed, signed copy and should keep a copy for their records.

PLEASE READ THESE STATEMENTS CAREFULLY

I authorize the use and disclosure of health information about me as described below.

Health Information to be Used or Disclosed: I understand this authorization applies to information about: my past, present, or future physical or mental health or condition and may include facts about my other insurance coverage, hazardous activities, finances, vocation, and other personal traits. This information may come from my medical records including, but not limited to prescription history, diagnoses and treatment for illnesses and conditions including, but not limited to, mental illness and the use of drugs, alcohol and tobacco, but excluding psychotherapy notes and information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC, or other information not permitted to be disclosed under applicable law.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: Supreme Council of the Royal Arcanum (Royal Arcanum); its insurance support organizations; its affiliates and reinsurers; care providers, treatment facilities, insurers, pharmacy benefit managers, the Medical Information Bureau (MIB) and consumer reporting agencies.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: care providers or evaluators, physicians, chiropractors, physical therapists, psychologists, drug, alcohol, and mental health counselors, pharmacy benefit managers and other health professionals; treatment facilities including hospitals, clinics, drug or alcohol treatment or consultation facilities, nursing homes, mental health facilities, ambulatory care centers and other medical or medically related facilities.

In addition, I authorize Royal Arcanum to disclose collected information to other insurers, reinsurers and the Medical Information Bureau (MIB). The Medical Information Bureau (MIB) and consumer reporting agencies may only disclose information as set forth in a contract with a member company or organization.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my insurance application; determine premium amounts, adjudicate claims and to support the operations of health plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization and that a copy of it is as valid as the original; (2) this Authorization will be valid for 30 months from the date signed; (3) I may revoke this Authorization by sending a written request for revocation to Royal Arcanum at the Medicare Supplement Administrative Office identified above; (4) if I do not sign this Authorization, or revoke it as provided for above, my application may be declined; (5) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization; and (6) some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Applicant/Insured please complete this section.

Signature of Applicant/Insured ✖ _____ Date _____

Printed Name of Applicant/Insured _____ Certificate Number (if known) _____

City _____ State _____ Zip _____

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In addition, I authorize Royal Arcanum to disclose collected information to other insurers, reinsurers and the Medical Information Bureau (MIB). The Medical Information Bureau (MIB) and consumer reporting agencies may only disclose information as set forth in a contract with a member company or organization.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my insurance application; determine premium amounts, adjudicate claims and to support the operations of health plans.

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Applicant/Insured please complete this section.

Signature of Applicant/Insured ✖ _____ Date _____

Printed Name of Applicant/Insured _____ Certificate Number (if known) _____

City _____ State _____ Zip _____

SUPREME COUNCIL OF THE ROYAL ARCANUM
AN INTERNATIONAL FRATERNITY PROVIDING FAMILY PROTECTION
Medicare Supplement Administrative Office
PO Box 13770, Oklahoma City, OK 73113

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 information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a certificate to be issued by Supreme Council of the Royal Arcanum. Your new certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the certificate.

You should review this 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 certificate.

STATEMENT TO APPLICANT BY AGENT: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement certificate 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 certificate 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 Medicare Part D
- ☐ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment

_____

- ☐ Other (please specify)

_____

(1) **NOTE:** If the issuer of the Medicare supplement certificate 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 certificate. This could result in denial or delay of a claim for benefits under the new certificate, whereas a similar claim might have been payable under your present policy/certificate.

(2) State law provides that your replacement 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 certificate (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy/certificate.

(3) If, you still wish to terminate your present policy/certificate 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 certificate 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/certificate until you have received your new certificate and are sure that you want to keep it.

✖ _____ _____
Signature of Agent Date

✖ _____ _____
Signature of Applicant Date

_____
Printed Name and Address of Agent

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

_____

- ☐ Other (please specify)

_____

(1) **NOTE:** If the issuer of the Medicare supplement certificate 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 certificate. This could result in denial or delay of a claim for benefits under the new certificate, whereas a similar claim might have been payable under your present policy/certificate.

(2) State law provides that your replacement 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 certificate (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy/certificate.

(3) If, you still wish to terminate your present policy/certificate 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 certificate 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/certificate until you have received your new certificate and are sure that you want to keep it.

✖ _____ _____
Signature of Agent Date

✖ _____ _____
Signature of Applicant Date

_____
Printed Name and Address of Agent

SUPREME COUNCIL OF THE ROYAL ARCANUM
An International Fraternity
Home Office: 61 Batterymarch Street, Boston, MA 02110
Administrative Office: PO Box 13770, Oklahoma City, OK 73113

Applicant's Name: _____

Certificate Number: _____

Name of Existing Insurer: _____

Expiration Date of Existing Insurance: _____

SERVICE	BENEFIT	MEDICARE PAYS	EXISTING COVERAGE	SUPPLEMENT PAYS	YOU PAY
Hospital Inpatient	First 60 Days 61st to 90th Day 91st to 150th Day (Lifetime Reserve) Beyond 150 Days	All But $1,408 All But $352 All But $704 Nothing			
Skilled Nursing Home Care	First 20 Days Additional 80 Days Beyond 100 Days	100% of Cost All But $176 Nothing			
Medical Expense	Physician's Services in Hospital, office or home; inpatient and outpatient medical services and supplies at a hospital; physical and speech therapy and ambulance	80% of Medicare Determined Allowable Charges After $198 Deductible			
Prescription Drugs		Inpatient Prescription Drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant.			

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

Date: _____ Applicant Signature: _____

Insurance Producer Signature: _____

Supreme Council of the Royal Arcanum

Outline of Coverage
Medicare Supplement Benefit Plans A, D, F and N
Benefit Chart of Medicare Supplement Plans Sold On or After January 1, 2020

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

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

Benefits	Plans Available to All Applicants								Plans Available ONLY to those first eligible before 01/01/2020	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2020[2]					$5,880[2]	$2,940[2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,340 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Supreme Council of the Royal Arcanum

Monthly Premium Rates*

ZIP Codes starting with: 609-629

Standard Plans – Preferred

FEMALE				Attained	MALE			
Plan A	Plan D	Plan F	Plan N	Age	Plan A	Plan D	Plan F	Plan N
273.01	289.55	315.92	239.96	0-64	313.96	332.99	363.31	275.95
101.18	107.31	119.51	78.32	65	116.35	123.40	137.44	90.06
101.18	107.31	119.51	78.32	66	116.35	123.40	137.44	90.06
101.18	107.31	119.51	78.32	67	116.35	123.40	137.44	90.06
102.69	108.92	121.30	80.12	68	118.10	125.25	139.50	92.14
105.00	111.36	123.73	81.96	69	120.75	128.07	142.29	94.26
107.62	114.15	126.82	84.01	70	123.77	131.27	145.84	96.61
110.85	117.57	130.63	86.11	71	127.48	135.21	150.22	99.03
114.18	121.10	134.69	89.55	72	131.31	139.26	154.89	102.99
117.61	124.73	138.76	93.14	73	135.25	143.44	159.57	107.11
121.72	129.10	143.61	97.33	74	139.98	148.46	165.15	111.93
125.98	133.62	148.64	101.71	75	144.88	153.66	170.93	116.96
130.39	138.29	153.79	106.29	76	149.95	159.04	176.86	122.23
134.95	143.13	158.86	111.07	77	155.20	164.60	182.69	127.73
140.45	148.96	164.10	116.07	78	161.52	171.31	188.72	133.48
146.07	154.92	169.03	120.71	79	167.98	178.16	194.38	138.82
151.33	160.50	175.11	125.54	80	174.03	184.57	201.38	144.37
155.99	166.28	181.42	130.56	81	179.39	191.22	208.63	150.14
160.79	172.26	187.95	135.78	82	184.91	198.10	216.14	156.15
166.58	178.46	194.71	141.21	83	191.57	205.23	223.92	162.39
172.58	184.89	201.72	146.86	84	198.47	212.62	231.98	168.89
178.79	191.55	208.99	152.73	85	205.61	220.28	240.33	175.64
186.17	198.44	216.51	158.84	86	214.09	228.21	248.99	182.67
193.84	205.58	224.30	165.20	87	222.91	236.42	257.95	189.98
200.82	212.98	232.38	171.81	88	230.94	244.93	267.24	197.58
208.04	220.65	240.74	178.68	89	239.25	253.75	276.86	205.48
215.53	228.60	249.41	185.83	90	247.86	262.89	286.82	213.70
223.29	236.83	258.39	193.26	91	256.79	272.35	297.15	222.25
231.33	245.35	267.69	200.99	92	266.03	282.15	307.85	231.14
239.66	254.18	277.33	209.03	93	275.61	292.31	318.93	240.38
248.29	263.33	287.31	217.39	94	285.53	302.83	330.41	250.00
257.23	272.81	297.66	226.08	95	295.81	313.74	342.30	260.00
261.08	276.91	302.12	229.48	96	300.25	318.44	347.44	263.90
265.00	281.06	306.65	232.92	97	304.75	323.22	352.65	267.86
268.98	285.28	311.25	236.41	98	309.32	328.07	357.94	271.87
273.01	289.55	315.92	239.96	99	313.96	332.99	363.31	275.95

Add a One-Time Policy Fee of $25

A 7% Household Discount is available to those that qualify

A $1.00 monthly fraternal membership due will be added to the premium

Supreme Council of the Royal Arcanum

Monthly Premium Rates*

ZIP Codes starting with: 609-629

Standard Plans - Standard

FEMALE				Attained	MALE			
Plan A	Plan D	Plan F	Plan N	Age	Plan A	Plan D	Plan F	Plan N
313.96	332.99	363.31	275.95	0-64	361.06	382.94	417.81	317.34
116.35	123.40	137.44	90.06	65	133.80	141.91	158.05	103.57
116.35	123.40	137.44	90.06	66	133.80	141.91	158.05	103.57
116.35	123.40	137.44	90.06	67	133.80	141.91	158.05	103.57
118.10	125.25	139.50	92.14	68	135.81	144.04	160.42	105.96
120.75	128.07	142.29	94.26	69	138.86	147.28	163.63	108.39
123.77	131.27	145.84	96.61	70	142.33	150.96	167.72	111.10
127.48	135.21	150.22	99.03	71	146.60	155.49	172.75	113.88
131.31	139.26	154.89	102.99	72	151.00	160.15	178.13	118.44
135.25	143.44	159.57	107.11	73	155.53	164.96	183.50	123.17
139.98	148.46	165.15	111.93	74	160.98	170.73	189.93	128.72
144.88	153.66	170.93	116.96	75	166.61	176.71	196.57	134.51
149.95	159.04	176.86	122.23	76	172.44	182.89	203.38	140.56
155.20	164.60	182.69	127.73	77	178.48	189.29	210.10	146.89
161.52	171.31	188.72	133.48	78	185.75	197.00	217.03	153.50
167.98	178.16	194.38	138.82	79	193.18	204.88	223.54	159.64
174.03	184.57	201.38	144.37	80	200.13	212.26	231.59	166.02
179.39	191.22	208.63	150.14	81	206.30	219.90	239.92	172.66
184.91	198.10	216.14	156.15	82	212.65	227.82	248.56	179.57
191.57	205.23	223.92	162.39	83	220.31	236.02	257.51	186.75
198.47	212.62	231.98	168.89	84	228.24	244.51	266.78	194.22
205.61	220.28	240.33	175.64	85	236.45	253.32	276.38	201.99
214.09	228.21	248.99	182.67	86	246.20	262.44	286.33	210.07
222.91	236.42	257.95	189.98	87	256.35	271.88	296.64	218.47
230.94	244.93	267.24	197.58	88	265.58	281.67	307.32	227.21
239.25	253.75	276.86	205.48	89	275.14	291.81	318.38	236.30
247.86	262.89	286.82	213.70	90	285.04	302.32	329.85	245.75
256.79	272.35	297.15	222.25	91	295.31	313.20	341.72	255.58
266.03	282.15	307.85	231.14	92	305.94	324.48	354.02	265.81
275.61	292.31	318.93	240.38	93	316.95	336.16	366.77	276.44
285.53	302.83	330.41	250.00	94	328.36	348.26	379.97	287.50
295.81	313.74	342.30	260.00	95	340.18	360.80	393.65	299.00
300.25	318.44	347.44	263.90	96	345.28	366.21	399.56	303.48
304.75	323.22	352.65	267.86	97	350.46	371.70	405.55	308.03
309.32	328.07	357.94	271.87	98	355.72	377.28	411.63	312.65
313.96	332.99	363.31	275.95	99	361.06	382.94	417.81	317.34

Add a One-Time Policy Fee of $25

A 7% Household Discount is available to those that qualify

A $1.00 monthly fraternal membership due will be added to the premium

Supreme Council of the Royal Arcanum

Monthly Premium Rates*

ZIP Codes starting with: 600-608

Standard Plans – Preferred

FEMALE				Attained	MALE			
Plan A	Plan D	Plan F	Plan N	Age	Plan A	Plan D	Plan F	Plan N
330.31	350.33	382.23	290.32	0-64	379.85	402.88	439.56	333.87
122.41	129.83	144.59	94.75	65	140.77	149.30	166.28	108.97
122.41	129.83	144.59	94.75	66	140.77	149.30	166.28	108.97
122.41	129.83	144.59	94.75	67	140.77	149.30	166.28	108.97
124.25	131.78	146.76	96.93	68	142.88	151.54	168.77	111.47
127.04	134.74	149.70	99.16	69	146.09	154.95	172.15	114.04
130.21	138.10	153.44	101.64	70	149.75	158.82	176.45	116.89
134.12	142.25	158.04	104.18	71	154.24	163.59	181.75	119.81
138.14	146.52	162.96	108.35	72	158.86	168.49	187.40	124.60
142.29	150.91	167.88	112.68	73	163.63	173.55	193.06	129.59
147.27	156.19	173.75	117.76	74	169.36	179.62	199.82	135.42
152.42	161.66	179.83	123.05	75	175.29	185.91	206.81	141.51
157.76	167.32	186.06	128.59	76	181.42	192.42	213.97	147.88
163.28	173.17	192.20	134.38	77	187.77	199.15	221.03	154.54
169.93	180.23	198.55	140.43	78	195.42	207.26	228.33	161.49
176.73	187.44	204.50	146.04	79	203.23	215.55	235.18	167.95
183.09	194.18	211.86	151.88	80	210.55	223.31	243.64	174.67
188.73	201.17	219.49	157.96	81	217.04	231.35	252.42	181.65
194.54	208.42	227.39	164.28	82	223.72	239.68	261.50	188.92
201.55	215.92	235.58	170.85	83	231.78	248.31	270.92	196.48
208.80	223.69	244.06	177.68	84	240.12	257.25	280.67	204.34
216.32	231.75	252.85	184.79	85	248.77	266.51	290.77	212.51
225.24	240.09	261.95	192.18	86	259.02	276.10	301.24	221.01
234.52	248.73	271.38	199.87	87	269.70	286.04	312.09	229.85
242.96	257.69	281.15	207.86	88	279.41	296.34	323.32	239.04
251.71	266.96	291.27	216.18	89	289.46	307.01	334.96	248.60
260.77	276.57	301.76	224.82	90	299.88	318.06	347.02	258.55
270.16	286.53	312.62	233.82	91	310.68	329.51	359.51	268.89
279.88	296.84	323.87	243.17	92	321.87	341.37	372.46	279.65
289.96	307.53	335.53	252.90	93	333.45	353.66	385.86	290.83
300.40	318.60	347.61	263.01	94	345.46	366.39	399.76	302.47
311.21	330.07	360.13	273.53	95	357.89	379.58	414.15	314.57
315.88	335.02	365.53	277.64	96	363.26	385.28	420.36	319.28
320.62	340.05	371.01	281.80	97	368.71	391.06	426.66	324.07
325.43	345.15	376.58	286.03	98	374.24	396.92	433.06	328.93
330.31	350.33	382.23	290.32	99	379.85	402.88	439.56	333.87

Add a One-Time Policy Fee of $25

A 7% Household Discount is available to those that qualify

A $1.00 monthly fraternal membership due will be added to the premium

Supreme Council of the Royal Arcanum

Monthly Premium Rates*

ZIP Codes starting with: 600-608

Standard Plans - Standard

FEMALE				Attained	MALE			
Plan A	Plan D	Plan F	Plan N	Age	Plan A	Plan D	Plan F	Plan N
379.85	402.88	439.56	333.87	0-64	436.83	463.31	505.49	383.95
140.77	149.30	166.28	108.97	65	161.89	171.70	191.22	125.31
140.77	149.30	166.28	108.97	66	161.89	171.70	191.22	125.31
140.77	149.30	166.28	108.97	67	161.89	171.70	191.22	125.31
142.88	151.54	168.77	111.47	68	164.32	174.27	194.09	128.19
146.09	154.95	172.15	114.04	69	168.01	178.19	197.97	131.14
149.75	158.82	176.45	116.89	70	172.21	182.64	202.92	134.42
154.24	163.59	181.75	119.81	71	177.37	188.12	209.01	137.78
158.86	168.49	187.40	124.60	72	182.69	193.77	215.51	143.29
163.63	173.55	193.06	129.59	73	188.18	199.58	222.02	149.02
169.36	179.62	199.82	135.42	74	194.76	206.56	229.79	155.73
175.29	185.91	206.81	141.51	75	201.58	213.79	237.83	162.74
181.42	192.42	213.97	147.88	76	208.63	221.28	246.07	170.06
187.77	199.15	221.03	154.54	77	215.93	229.02	254.19	177.72
195.42	207.26	228.33	161.49	78	224.73	238.35	262.58	185.71
203.23	215.55	235.18	167.95	79	233.72	247.88	270.46	193.14
210.55	223.31	243.64	174.67	80	242.13	256.81	280.19	200.87
217.04	231.35	252.42	181.65	81	249.60	266.05	290.28	208.90
223.72	239.68	261.50	188.92	82	257.28	275.63	300.73	217.26
231.78	248.31	270.92	196.48	83	266.54	285.55	311.55	225.95
240.12	257.25	280.67	204.34	84	276.14	295.83	322.77	234.99
248.77	266.51	290.77	212.51	85	286.08	306.48	334.39	244.38
259.02	276.10	301.24	221.01	86	297.88	317.52	346.43	254.16
269.70	286.04	312.09	229.85	87	310.15	328.95	358.90	264.33
279.41	296.34	323.32	239.04	88	321.32	340.79	371.82	274.90
289.46	307.01	334.96	248.60	89	332.88	353.06	385.21	285.90
299.88	318.06	347.02	258.55	90	344.87	365.77	399.07	297.33
310.68	329.51	359.51	268.89	91	357.28	378.94	413.44	309.23
321.87	341.37	372.46	279.65	92	370.14	392.58	428.32	321.59
333.45	353.66	385.86	290.83	93	383.47	406.71	443.74	334.46
345.46	366.39	399.76	302.47	94	397.28	421.35	459.72	347.84
357.89	379.58	414.15	314.57	95	411.58	436.52	476.27	361.75
363.26	385.28	420.36	319.28	96	417.75	443.07	483.41	367.18
368.71	391.06	426.66	324.07	97	424.02	449.71	490.66	372.68
374.24	396.92	433.06	328.93	98	430.38	456.46	498.02	378.27
379.85	402.88	439.56	333.87	99	436.83	463.31	505.49	383.95

Add a One-Time Policy Fee of $25

A 7% Household Discount is available to those that qualify

A $1.00 monthly fraternal membership due will be added to the premium

Disclosures. Use this outline to compare benefits and premiums among certificates.

Premium Information. Supreme Council of the Royal Arcanum (Royal Arcanum) can only raise your premium if we raise the premium for all certificates like yours in the same geographic area of the state where you live. Premiums for this certificate will increase due to the increase in your age.

Household Premium Discount. You may be eligible for a Household Premium Discount if: (1) you reside with your spouse, including validly recognized civil union and domestic partners, who owns or is issued a Medicare supplement certificate written by Royal Arcanum or (2) for the past year you have resided with household resident (at least one, no more than three) and at least one owns or is issued a Medicare supplement certificate with Royal Arcanum. The discounted rate will be 7 percent lower than the individual rates as long as both certificates remain in force.

Read Your Certificate Very Carefully. This is only an outline describing your certificate's most important features. The certificate is your insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and us.

Right to Return Certificate. If you find that you are not satisfied with your certificate, you may return it to us at our Medicare Supplement Administrative Office PO Box 13770, Oklahoma City, OK 731134. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all of your payments.

Certificate Replacement. If you are replacing another health insurance certificate/policy, do NOT cancel it until you have actually received your new certificate and are sure you want to keep it.

Notice. The certificate may not fully cover all of your medical costs. Neither we nor our agents are connected with Medicare. This outline does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

Complete Answers Are Very Important. When you fill out the application for the new certificate, be sure to answer truthfully and completely all questions about your medical and health history. We may cancel your certificate and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLEASE REFER TO YOUR CERTIFICATE FOR DETAILS.

Plan A

Medicare Part A – Hospital Services Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan A Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,408	$0	$1,408 Part A Deductible
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
- Once lifetime reserve days are used			
▪ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th days	All but $176 a day	$0	Up to $176 a day
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the certificate's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan A

Medicare Part B – Medical Services per Calendar Year

*Once you have been billed $198 of Medicare Eligible Expenses for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A Pays	You Pay
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare approved amounts*	$0	$0	$198 Part B Deductible
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $198 of Medicare approved amounts*	$0	$0	$198 Part B Deductible
Remainder of Medicare approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan A Pays	You Pay
Home Health Care Medicare Approved Services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
▪ First $198 of Medicare approved amounts*	$0	$0	$198 Part B Deductible
▪ Remainder of Medicare approved amounts	80%	20%	$0

Plan D

Medicare Part A – Hospital Services Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan D Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,408	$1,408 Part A Deductible	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
- Once lifetime reserve days are used			
▪ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th days	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the certificate's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan D

Medicare Part B – Medical Services per Calendar Year

*Once you have been billed $198 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan D Pays	You Pay
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare approved amounts*	$0	$0	$ 198 Part B Deductible
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $198 of Medicare approved amounts*	$0	$0	$ 198 Part B Deductible
Remainder of Medicare approved amounts	80%	$20%	$0
Clinical Laboratory Services – Tests for Diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan D Pays	You Pay
Home Health Care Medicare Eligible Services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
▪ First $198 of Medicare approved amounts*	$0	$0	$ 198 Part B Deductible
▪ Remainder of Medicare approved amounts	80%	20%	$0

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan D Pays	You Pay
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

Plan F

Medicare Part A – Hospital Services Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan F Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,408	$1,408 Part A Deductible	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
- Once lifetime reserve days are used			
▪ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th days	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the certificate's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan F

Medicare Part B – Medical Services per Calendar Year

*Once you have been billed $198 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F Pays	You Pay
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare approved amounts*	$0	$198 Part B Deductible	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $198 of Medicare approved amounts*	$0	$198 Part B Deductible	$0
Remainder of Medicare approved amounts	80%	$20%	$0
Clinical Laboratory Services – Tests for Diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan F Pays	You Pay
Home Health Care Medicare Approved Services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
▪ First $198 of Medicare approved amounts*	$0	$198 Part B Deductible	$0
▪ Remainder of Medicare approved amounts	80%	20%	$0

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan F Pays	You Pay
Foreign Travel Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

Plan N

Medicare Part A – Hospital Services Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan N Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,408	$1,408 Part A Deductible	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
- Once lifetime reserve days are used			
▪ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100 days	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the certificate's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan N

Medicare Part B – Medical Services per Calendar Year

*Once you have been billed $198 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan N Pays	You Pay
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare approved amounts*	$0	$0	$198 Part B Deductible
Remainder of Medicare approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The Copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (above Medicare approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $198 of Medicare approved amounts*	$0	$0	$198 Part B Deductible
Remainder of Medicare approved amounts	80%	$20%	$0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan N Pays	You Pay
Home Health Care Medicare Approved Services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
▪ First $198 of Medicare approved amounts*	$0	$0	$198 Part B Deductible
▪ Remainder of Medicare approved amounts	80%	20%	$0

Plan N

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan N Pays	You Pay
Foreign Travel Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

SUPREME COUNCIL OF THE ROYAL ARCANUM

Your Health Information: Your Rights - Our Rights and Duties

Please review this notice carefully.

HIPAA NOTICE OF PRIVACY PRACTICES

What is the Purpose of this Notice?

This notice describes: (1) how We, Supreme Council of the Royal Arcanum (Royal Arcanum) use and disclose your Protected Health Information, (2) how We protect that information, and (3) your rights regarding that information.

Definitions

Your Protected Health Information is information about you that is created or received by Royal Arcanum that either identifies you or, based on a reasonable belief, could be used to identify you, and that information relates to:

- Your past, present or future physical or mental health condition.
- Health care provided to you; or
- The past, present or future payment for the provision of health care to you.

A Health Plan means the following individual or group insurance products: major medical, Medicare supplement, hospital indemnity, long term care, dental, specified disease (such as cancer) and pharmacy benefits insurance products or plans.

Use and Disclosure of Protected Health Information

We will use and disclose your Protect Health Information as described below.

With your written Authorization

If you have given us written authorization to release your Protected Health Information, We have the right to use and disclose your Protected Health Information as provided in that authorization. Such an authorization must be in writing, and you have the right to revoke it at any time by contacting us at the address given below in this notice. Any information We have released with your authorization, but before you revoke it, will not be affected by your later revocation of that authorization.

Without your authorization

Even if you have not given us written authorization, We may use and disclose your Protected Health Information as described below:

- For payment purposes, such as paying you benefits or a claim for services provided to you by healthcare providers.
- To a doctor, a hospital, or other healthcare provider so you can receive health care.
- To an affiliate or to a business associate outside of Royal Arcanum, if they need Protected Health Information to provide a service to us and have confirmed that they follow the HIPAA rules relating to the protection of Protected Health Information.
- To your family and friends if you are unavailable to communicate, such as in an emergency.
- For performing underwriting activities. But, We will not use any results of genetic testing except for issuing long term care or to ask questions regarding family history.
- To your family and friends or any other person you identify, provided the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, We may confirm whether or not the claim has been received and paid.
- For healthcare operation activities including business management, accreditation and licensing, peer review, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, and processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, determining premiums and other functions related to servicing your Health Plan.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To provide payment information for Internal Revenue Service substantiation, as permitted by law.
- To public health agencies if We believe there is a serious health or safety threat to you.
- To appropriate authorities, as required by law, when there are issues about abuse, neglect, or domestic violence.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- To assist in disaster relief efforts.
- For compliance programs and health oversight activities.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances.
- To workers' compensation agencies if necessary for your workers' compensation benefit determination or as permitted by law.
- To a government oversight agency conducting audits, investigations, or civil or criminal proceedings, if authorized or required by law.
- To your plan sponsor, if applicable, for their benefits administration activities.
- For public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you, if you have not directed us to not do so, as described in this notice.
- To the appropriate government agency, if necessary to report adverse events, product defects or to participate in product recalls.

- To law enforcement officials to report wounds, injuries or crimes, as required by law.
- To coroners and/or funeral directors consistent with law.
- For a national security or intelligence activity or, if you are a member of the military, as required by law.
- As otherwise permitted or required by law.

How do We protect your Protected Health Information

We protect the privacy of your Protected Health Information by complying with Federal and State laws and our own policies regarding the privacy and confidentiality of your information.

We have procedures in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how We use or disclose your information
- Training our associates about our privacy policies and procedures

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your Protected Health Information.

Your information may continue to be used as permitted in this notice after your coverage with us is ended or your coverage with us is not issued. We will not retain the information after the required legal retention period.

Your Rights and Choices

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information We have about you.
- Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request.
- We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete.
- Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if We do not.

Ask us to limit what We use or share

- You can ask us not to use or share certain health information for treatment, payment, visit scheduling, or our operations.
- We are not required to agree to your request, and We may say “no” if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who We shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
- We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before We take any action on a request such person makes on your behalf.

File a complaint if you feel your rights are violated

- You can complain to us if you feel We have violated your rights by contacting us using the information below.
- You also can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what We share.

If you have a clear preference for how We share your information in the situations described below, talk to us. Tell us what you want us to do, and We will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, We may go ahead and share your information if We believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We *never* share your information in the following cases, unless you give us written permission:

- Marketing purposes
- Sale of your information

Changes to this Notice

We will comply with the terms of this notice for as long as it remains in effect. We reserve the right to change it and how We will treat all Protected Health Information whether received by us before or after the effective date of the new notice.

Other Information

Effect of State Law

If you reside in a State whose law requires greater protection of your Protected Health Information than stated above, We will comply with those more restrictive or stringent requirements.

Effective Date

This notice is effective April 1, 2020.

Entities this Notice applies to

This notice applies to Supreme Council of the Royal Arcanum

Contact Information

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

Supreme Council of the Royal Arcanum
Nicholas G. Benoit
61 Batterymarch Street
Boston, MA 02110
Tel: (857) 317-3640

SUPREME COUNCIL OF THE ROYAL ARCANUM
PRIVACY COMMITMENT OF OUR MEMBERS

Title V of Gramm-Leach-Bliley Act enacted by Congress in 1999, as implemented by the various state legislatures, requires the adoption of a privacy protection policy to safeguard non-public personal information. The following is a privacy commitment which has been approved by the Executive Committee for the benefit of our members.

You have provided the Royal Arcanum with certain non-public personal information, such as your name age, residence, marital status and social security number. If you have applied for life insurance, you also provided us with employment and medical information and authorized us to obtain further information concerning your health history, mode of living, avocations and other personal characteristics. Based on this authorization, information necessary to underwrite your applications has been collected from others.

We maintain the highest level of confidentiality concerning your nonpublic personal information. The employees at the Home Office have been trained in the careful handling and protection of such information. Oversight of these matters is rigorous and our employees understand that improper disclosure of nonpublic personal information is a serious matter with severe consequences.

We are a fraternal benefit society that has always been committed to protecting the privacy of our members. There are no affiliated financial institutions or third party, non-affiliates which have access to your nonpublic personal information. We never sell lists of names and addresses of our members to any vendor of goods or services.

Should we be required to disclose information in connection with civil or criminal matters, or by a governmental authority such as an administrative or judicial order including a search warrant or subpoena we must comply, but such instances are exceedingly rare.

Organizations assisting us with our operations are required to adhere to the same strict standards of confidentiality as we do

Finally, please be assured that the information in your file will always be available to you for modification, correction or change when appropriate.

We do not disclose any nonpublic personal information about our members or former members, spouses or beneficiaries to anyone, except as provided by law.

Discrimination is Against the Law

Supreme Council of the Royal Arcanum (Royal Arcanum) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Royal Arcanum does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Royal Arcanum:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Royal Arcanum's Customer Services Department at 833-585-0550.

If you believe that Royal Arcanum has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Nicholas G. Benoit
Chief Operating Officer
Royal Arcanum
61 Batterymarch Street
Boston, MA 02110
Phone: (857) 317-3640
Fax: (617) 426-2322
Email: nbenoit@royalarcanum.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Royal Arcanum is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-524-3629.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-524-3629.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-524-3629.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-524-3629.

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa1-888-524-3629.

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1-888-524-3629.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-524-3629.

العربيـــة (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة المجانية بالمجان لك تتوافر. اتصل برقم 1-888-524-3629.

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-888-524-3629.

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-524-3629.

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. بمی باشد. با 1-888-524-3629 تماس بگیرید.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-524-3629 まで、お電話にてご連絡ください。

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-524-3629 पर कॉल करें।

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ1-888-524-3629.

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-524-3629.

اُردُو (Urdu)
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-888-524-3629.

http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

RECEIPT

Receipt

Please Note: All premium checks must be made payable to Supreme Council of the Royal Arcanum. ***Do not make check 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 certificate 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 certificate applied for has been issued.

Date receipt and outline of coverage was prepared _____ , 20 _____

By_____

Agent's Signature

Supreme Council of the Royal Arcanum

Administrative Office: PO Box 16368, Oklahoma City, OK 73113

RA APP RECEIPT(8-2020)