COMPANION
WHOLE LIFE INSURANCE
Insured by American Retirement Life Insurance Company

Application Booklet for

WHOLE LIFE *in* PENNSYLVANIA

- APPLICATION
- ELECTRONIC FUNDS TRANSFER AGREEMENT
- MIB PRE-NOTICE
- HIPAA NOTICE
- NOTICE AND CUSTOMER INFORMATION FORM
- ACCELERATED BENEFIT TERMINAL ILLNESS DISCLOSURE
- DISCLOSURE STATEMENT
- LIFE REPLACEMENT NOTICE

BEING TRUE TO **YOURSELF**
IS THE FIRST STEP TO
BEING TRULY **HEALTHY.**

GO YOU®

Cigna®

AMERICAN RETIREMENT LIFE INSURANCE COMPANY
11200 Lakeline Blvd., Suite 100, Austin, TX 78717
Mailing address: PO Box 559015, Austin, TX 78755-9015

Whole Life Insurance Application

☐ NEW BUSINESS ☐ REINSTATEMENT **PV Case #**_____

Requested Effective Date _____ (if no Date, we will assign the approval date as the Effective Date of the Application)

SECTION I: APPLICANT INFORMATION (PLEASE PRINT)

Name of Applicant First	MI	Last	Age	Date of Birth MM	DD	YYYY	State of Birth

Resident Street Address (no PO Box) _____

City _____ **State** _____ **Zip** _____

Mailing Address (if different from above) _____

City _____ **State** _____ **Zip** _____

Phone ( ) _____ **Email Address** _____

Social Security No.	Sex M/F	Height Ft.	In.	Weight Lbs.	Have you used tobacco within the last 12 months?
– –					Yes ☐ No ☐

SECTION II: BILLING

Method (select one of the following):

☐ Direct Bill

☐ Bank Draft (complete the EFT Agreement)

Mode (select one of the following):

☐ Monthly (n/a with Direct Bill)

☐ Quarterly

☐ Semi-annually

☐ Annually

SECTION III: WHOLE LIFE COVERAGE APPLIED FOR

Whole Life Insurance: Benefit Amount $_____

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship

Owner, if other than the Proposed Insured Name	Relationship	Social Security No.
		– –

Address

SECTION IV: TOTAL PREMIUM WITH APPLICATION

Initial premium: ☐ Draft bank account ☐ Check enclosed (payable to ***American Retirement Life Insurance Company)***

*Modal Premium includes a $36 annual policy fee

Policy Modal Premium* $_____

Total Premium with Application $_____

SECTION V: EXISTING COVERAGE & REPLACEMENT (IF APPLYING FOR WHOLE LIFE INSURANCE, PLEASE COMPLETE THIS SECTION)

1) Do you, the Applicant, have existing individual life insurance policies or individual annuity contracts with this or any other company? ..... YES ☐ NO ☐
If "YES", (a) the Applicant and Agent must complete the required "Important Notice: Replacement of Life Insurance or Annuities" form; (b) the Agent must complete the Section "Agent Provided Sales Material Statement" below and sign; and (c) provide the following information (use additional sheet, if needed):

Insurance Company Name and Address	Contract or Policy Number	Is Coverage being Replaced?
		YES ☐ NO ☐
		YES ☐ NO ☐

Applicant's Signature / Printed Name _____ Date _____

Agent's Signature / Printed Name _____ Date _____

2) **AGENT PROVIDED SALES MATERIAL STATEMENT** (MUST BE COMPLETED BY THE AGENT ONLY IF THE APPLICANT IS REPLACING EXISTING LIFE INSURANCE OR ANNUITY): I hereby certify that in connection with my presentation to the Applicant herein, I only used sales material that was previously approved by American Retirement Life Insurance Company and that I left with or provided to the Applicant a copy of the sales material used in my presentation to the Applicant.

Agent's Signature / Printed Name _____ Date _____

SECTION VI: MEDICAL QUESTIONS

PLEASE ANSWER ALL QUESTIONS IN THIS SECTION

It is important that you provide truthful and accurate answers to the questions in this section as your answers form the basis of our determination of your eligibility for this coverage. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage.

PART A: MEDICAL QUESTIONS - If the answer to any question in Part A is "YES", the Applicant is not eligible for coverage.

	YES	NO
1) Are you currently confined or scheduled for admission to a hospital, nursing facility, or assisted living facility or are you receiving home health care services?	☐	☐
2) Do you require or receive any assistance with bathing, transferring, toileting, eating, or dressing?	☐	☐
3) Are you currently bedridden or do you use the assistance of a wheelchair, walker, or motorized mobility aid?	☐	☐
4) Within the past two (2) years, have you:		
a) been diagnosed by a member of the medical profession with a terminal illness or been hospitalized more than two (2) times, received home health care services more than three (3) times, or been confined to a nursing facility for more than thirty (30) days?	☐	☐
b) been diagnosed with or treated (other than with maintenance medication) by a member of the medical profession for angina, heart attack, atrial fibrillation, cardiomyopathy, congestive heart failure, cardiac or vascular angioplasty, stent placement, peripheral vascular disease, coronary bypass, carotid artery disease, coronary artery disease, or heart disease; had heart or heart valve surgery or required the implantation of cardiac pacemaker or defibrillator?	☐	☐
c) had a stroke or Transient Ischemic Attack (TIA)?	☐	☐
5) Do you have now or in the last two (2) years have you received from a member of the medical profession advice or treatment, or been advised to have treatment or surgery, or taken medication for the following conditions:		
a) hepatitis (other than hepatitis A), cirrhosis of the liver, or other liver disease?	☐	☐
b) major depression, bipolar disorder, schizophrenia, or a paranoid disorder?	☐	☐
c) diabetes requiring more than 50 units of insulin daily to control or diabetes with any of the following: neuropathy, retinopathy, vascular disease, or hypertension requiring more than two medications to control?	☐	☐
d) chronic kidney disease, Addison's Disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant?	☐	☐
e) internal cancer, leukemia, malignant melanoma, Hodgkin's Disease, or lymphoma?	☐	☐
f) alcohol or drug abuse?	☐	☐
g) paralysis, hemophilia, osteoporosis with fractures, or unrepaired aneurysm?	☐	☐
h) Paget's Disease, rheumatoid or disabling arthritis, systemic lupus, or other connective tissue disorder?	☐	☐

	YES	NO
6) Do you have now or at any time have you received from a member of the medical profession advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions:		
a) Parkinson's Disease, myasthenia gravis, multiple or amyotrophic lateral sclerosis, Lou Gehrig's Disease, muscular dystrophy, cerebral palsy, dementia, senility, Alzheimer's Disease, or organic brain disorder?	☐	☐
b) emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic Obstructive Lung Disease (COLD), or any chronic lung or respiratory disorder requiring the use of oxygen?	☐	☐
c) amputation caused by disease or organ transplant other than corneas?	☐	☐
7) Have you ever been diagnosed with or received medical advice or treatment from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection?	☐	☐
8) Do you have now or in the last three (3) years have you received from a member of the medical profession advice or treatment, or been advised to have treatment or surgery, or taken medication for anemia requiring repeated blood transfusions, or any other blood disorder?	☐	☐
9) Has surgery been advised by a member of the medical profession but not performed or is any surgery anticipated, including but not limited to joint replacement or cataract surgery?	☐	☐
10) Have medical tests (other than mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only), treatment, or therapy been advised by a member of the medical profession but not performed?	☐	☐

PART B: MEDICAL QUESTIONS - If the answer to any of the following questions is "YES", you might be eligible for coverage. Please provide complete details as requested below.

	YES	NO
11) Within the past two (2) years, have you been declined for Life, Health, or Supplemental Insurance? ..... If "YES", please provide details including the date of the declination, the type of coverage applied for, and the reason for the declination here: _____ _____	☐	☐
12) In the past two (2) years, have you had PSA levels greater than 6.0 or been diagnosed by a member of the medical profession with dysplasia of the cervix classified as a level 3.0 or higher? ..... If "YES", please provide details in the table below.	☐	☐

Test	Results	Diagnosis

	YES	NO
13) Within the past two (2) years, have you taken any medication for any heart or vascular disease other than hypertension? ..... If "YES" or if you are taking any medications, give complete details in Part C Medications.	☐	☐

PART C: MEDICATIONS

14) Please list any prescription medications taken or prescribed in the last two (2) years because you were medically diagnosed and/or advised to by a member of the medical profession.
If you are not taking any medications, please check here: ☐ I am not taking any medications.

Medication	Dates Taken	Condition Taken for

AGENT NOTES - Please provide any other information that you believe may assist in our underwriting determination:

_____

_____

_____

_____

_____

_____

_____

SECTION VII: IMPORTANT STATEMENTS FOR APPLICANT TO READ

I hereby apply to American Retirement Life Insurance Company for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) No agent has the authority to waive the answer to any questions on the Application; (2) No insurance will be effective until a) a policy has been issued by the Company and b) the initial premium has been paid; and (3) I have received the MIB Pre-Notice.

CAUTION: Please review your answers to the questions on the Application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

I ☐ ***grant*** ☐ ***do not grant*** my authorization to receive information or presentation of materials describing other insurance products.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

A recorded telephone interview may be used as part of the underwriting on your Application for Insurance.

Telephone Number ( ) _____ Best time to call _____

Applicant's Printed Name _____

Signature of Applicant _____ Date _____

SECTION VIII: AGENT(S) CERTIFICATION

Do you have knowledge or reason to believe the replacement of existing insurance may be involved? YES ☐ NO ☐

If "YES", give name of Company, reason, and termination date _____

_____

I certify that I have interviewed the Applicant, asked all of the questions as written on the Application, and I have truly and accurately recorded on the Application the information supplied to me by the Applicant.

Printed Name of 1st Licensed Agent	Signature of 1st Licensed Agent	Writing Number	Percentage
Printed Name of 2nd Licensed Agent	Signature of 2nd Licensed Agent	Writing Number	Percentage

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

AMERICAN RETIREMENT LIFE INSURANCE COMPANY® • PO BOX 559015 • AUSTIN, TX 78755-9015

Proposed Insured's Name		Policy Number (if available)
Financial Institution Name and Telephone Number		
Financial Institution Address		
9-digit Routing Number	Account Number	Requested Withdrawal Date (1st - 28th)

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

For Checking Account: Please tape a VOIDED check in this box.

For Savings Account: Please attach a letter from the bank stating the account and routing number of your savings account.

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to American Retirement Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize American Retirement Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event American Retirement Life Insurance Company mistakenly deposits funds into my account, I authorize American Retirement Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR AMERICAN RETIREMENT LIFE INSURANCE COMPANY: It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by American Retirement Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by American Retirement Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by American Retirement Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured) **Payor's Address**

Print name of Depositor (as it appears on account) **Signature of Depositor** **Date**

MIB, Inc., Pre-Notice

AMERICAN RETIREMENT LIFE INSURANCE COMPANY®
PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

Information regarding your insurability will be treated as confidential. American Retirement Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

American Retirement Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company®.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information. However, MIB, Inc., information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB, Inc.
4. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 26580, Austin, Texas 78755-0580.
6. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
7. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
8. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
9. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

_____

Applicant's Name	**Name of Applicant's Personal Representative, if applicable**
Applicant's Social Security Number	**Relationship of Personal Representative to the Applicant**
Signature of Applicant **Date**	**Signature of Personal Representative** **Date**
Signature of Company's Agent **Date**	

A signed copy of this form will be provided with the policy if issued and any other time upon request.

American Retirement Life Insurance Company®
PO Box 559015, Austin, TX 78755-9015 • 866-459-4272

Notice and Customer Information Form

To help the government fight the funding of terrorism and money laundering activities, Federal law requires us to obtain all relevant customer-related information necessary to run an effective anti-money laundering program.

What this means to you: When submitting an application/order ticket/request form, we ask that the producer obtain the client's name, street address, date of birth, tax identification number, and other customer-related information that will allow us to identify the customer and fulfill our obligations under Federal law. Picture documentation, such as a driver's license or other identifying documents, will be used to verify the information given at the time of the sale.

By acknowledging receipt of this Notice and Customer Information Form, the undersigned authorizes any law enforcement agency, public or private institution, information service bureau, or other entity contacted by the Company identified above to furnish information sufficient to confirm the personal information of the undersigned as required by Federal law. This information is confidential and will not be used for any other purpose. The undersigned hereby releases all persons, agents and agencies, and entities providing confirming information from any and all liability arising out of the request for or the release of confirming information.

The owner information section must be completed in its entirety. If identification documents are not available, the customer must sign the form and the information will be verified by the Company.

The following information must be obtained for each tax identification number or social security number disclosed on the application for insurance.

I. **Owner**

FEIN/SSN	**Owner Name**	**Verification of ID** ☐ Driver's License/State ID ☐ Passport ☐ Other _____ ☐ Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)	**State/Country**	
Date of Birth	**Occupation**		**Number**	
Employer			**Date Issued**	**Exp. Date**

Additional Owner

FEIN/SSN	**Person's Name**	**Verification of ID** ☐ Driver's License/State ID ☐ Passport ☐ Other _____ ☐ Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)	**State/Country**	
Date of Birth	**Occupation**		**Number**	
Employer			**Date Issued**	**Exp. Date**

II. The source of funds for this transaction is _____

III. The purpose of this transaction is _____

Agent: I have examined and verified the customer's ID as noted above is true and correct to the best of my knowledge and belief.

_____ Agent's Printed Name

_____ Agent Number

_____ Agent's Signature

_____ Date

---------- **COMPLETE THIS PORTION ONLY IF THE APPLICANT DOES NOT HAVE IDENTIFICATION DOCUMENTS** ----------

Customer(s): I acknowledge the foregoing notice and certify that the foregoing information is true and correct to the best of my knowledge and belief.

_____ Owner's Printed Name

_____ Owner's Signature Date

_____ Additional Owner's Printed Name

_____ Additional Owner's Signature Date

American Retirement Life Insurance Company®
(Hereinafter called: the Company, We, Our, or Us)
Home Office: 1300 East Ninth Street, Cleveland, OH 44114
Administrative Office: PO Box 559015, Austin, TX 78755-9015
Customer Service: 866-459-4272

ACCELERATED BENEFIT TERMINAL ILLNESS RIDER DISCLOSURE STATEMENT

AN ACCELERATED BENEFIT THAT IS PAID ON ACCOUNT OF THIS RIDER WILL REDUCE THE DEATH BENEFITS OF THE POLICY. SUCH PAYMENT WILL ALSO REDUCE THE CASH VALUE OR OTHER VALUES OF THE POLICY, IF ANY. SOME PART OR ALL OF SUCH A PAYMENT MAY BE TAXABLE. AS WITH ALL TAX MATTERS, A TAX ADVISOR SHOULD BE CONSULTED.

What is an accelerated benefit? An accelerated benefit is the payment of a part of the proceeds of your life insurance policy before the death of an Insured. ("You" and "Your" refer to the Owner of the policy to which this rider is attached.)

Who can qualify for an accelerated benefit? An accelerated benefit may be paid with respect to the Insured or any additional Insured. The accelerated benefit will be paid only one time for each Insured.

When can I receive an accelerated benefit? Payment may be made to the Owner when an Insured has been diagnosed with a medical condition that results in a life expectancy of 12 months or less.

How much of the proceeds can be paid as an accelerated benefit? An accelerated benefit is paid from the Present Value of the Eligible Proceeds of your policy. The Eligible Proceeds are the death benefits of the policy (or combined policies) less any decreasing term riders and level term riders that will terminate within one year. Subject to the minimums and maximums described below, you may choose how much of the Eligible Proceeds are to be paid as an accelerated benefit.

In order to receive an accelerated benefit, you must have a least $10,000 in Eligible Proceeds. The Eligible Proceeds that are to be paid as an accelerated benefit must be at least $5,000. You may combine all policies that you have in force with us to satisfy these minimums.

You may not have more than 50% of your Eligible Proceeds paid as an accelerated benefit. You may not have more than $200,000 of Eligible Proceeds paid as an accelerated benefit. These maximums apply to the total of all policies you have in force with us.

When proceeds are to be paid as an accelerated benefit, is there a reduction for early payment? Yes, the Eligible Proceeds that are to be paid as an accelerated benefit are reduced to present value. The present value calculation takes into account the premiums we would have expected to receive in the future had the accelerated benefit not been elected, as well as an administrative fee. This means the amount you receive will always be less than the Eligible Proceeds you choose to be accelerated.

What is the administrative fee when an accelerated benefit is to be paid? We may charge an administrative fee of up to $100 when an accelerated benefit is to be paid. This fee will be included as par to the present value calculation. We will notify you if an administrative fee is charged.

How is the accelerated benefit paid? You may choose to have the accelerated benefit paid to you in a lump sum or in equal monthly installments. The Limited Life Expectancy Option provides for 12 months of installments.

What if the Insured dies before all payments are made? If the Insured dies before all payments are made, the present value of future payments will be paid to the beneficiary in a lump sum.

How will the payment of an accelerated benefit affect my policy? After the payment of an accelerated benefit, your policy will remain in force for a reduced Face Amount. The policy proceeds and all policy values will be reduced by the percentage of the Eligible Proceeds you elect to accelerate. Policy values that will be reduced include:

(a) death benefit face amount;
(b) future policy premiums (excluding the policy fee);
(c) cash values, if any;
(d) amounts available under the Reduced Paid-Up Nonforfeiture Option; and
(e) policy loan amounts outstanding.

Any policy fees associated with the policy will not be reduced.

Here is an example of how an accelerated benefit affects a policy:

Death Benefit (Eligible Proceeds) $100,000
Maximum Accelerated Benefits $ 50,000

	Death Benefit (Eligible Proceeds)	Premium plus any policy fees	Cash Value
Before accelerated payment	$100,000	$1,000	$26,000
After accelerated payment	$ 50,000	$ 500	$13,000

Do I have to pay an additional premium if the Rider is added to my policy? No, there is no additional premium charged if you add the rider to your policy.

When does the Rider terminate? The rider will terminate on the date an accelerated benefit is paid, the date you sent the company a written request to terminate the rider, or the date the policy terminates.

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Additional Insured Date

_____ _____
Signature of Owner Date

_____ _____
Signature of Agent or Company Representative Date

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_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Additional Insured Date

_____ _____
Signature of Owner Date

_____ _____
Signature of Agent or Company Representative Date

American Retirement Life Insurance Company®
PO Box 559015, Austin, TX 78755-9015

DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE. THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured _____ **Age** _____ **Sex** _____

Name of Agent Preparing Disclosure _____

Home or Agency Address of Agent _____

Telephone Number of Agent _____

Insurer: American Retirement Life Insurance Company

Direct all correspondence to: American Retirement Life Insurance Company, PO Box 26580, Austin, TX 78755-9004

	DESCRIPTIVE TITLE OF COVERAGE	FACE AMOUNT OF COVERAGE [If not applicable, DESCRIPTIVE TITLE OF COVERAGE]	FACE AMOUNT OF COVERAGE [If not known, PREMIUM FOR MODE QUOTED]
Policy	Final Expense Whole Life Policy		
Supplemental Benefit(s) (built into Policy)	Accelerated Benefit Terminal Illness Rider	This Rider will provide either a lump sum benefit amount or periodic payments upon the first diagnosis of a qualifying event. There is no charge for this Rider prior to the time a benefit is paid.	**The cost is included in the premium for the policy.**

The Face Amount of coverage of the **Whole Life Policy** changes as follows: **The Face Amount of the policy remains level for the life of the insured as long as the policy remains in force for the Whole Life Policy**.

The planned period premium is _____ The frequency to be paid is _____

RETURN TO COMPANY

Guaranteed Cash Value: If you continuously pay your premiums on this policy as they become due, you will have the following guaranteed cash surrender value for each $1,000 of Face Amount. You may borrow against this cash value at an annual **8.0%** loan interest rate.

Number of years Policy has been in force	Cash Value per $1,000 (of total Face Amount)
5	
10	
20	
Age 65	

A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

The prospective insured ☐ ***has*** ☐ ***has not*** requested an early delivery of the index (check appropriate box). Upon request, either the Company or Agent will furnish you with additional information about the insurance described.

APPLICANT CERTIFICATION

The undersigned does hereby certify that the written disclosure statement was given no later than the time that the application was signed by the Applicant.

_____ _____

Signature of Applicant Date

_____

Print or Type Name

RETURN TO COMPANY

American Retirement Life Insurance Company®
PO Box 559015, Austin, TX 78755-9015

DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE. THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured _____ **Age** _____ **Sex** _____

Name of Agent Preparing Disclosure _____

Home or Agency Address of Agent _____

Telephone Number of Agent _____

Insurer: American Retirement Life Insurance Company

Direct all correspondence to: American Retirement Life Insurance Company, PO Box 26580, Austin, TX 78755-9004

	DESCRIPTIVE TITLE OF COVERAGE	FACE AMOUNT OF COVERAGE [If not applicable, DESCRIPTIVE TITLE OF COVERAGE]	FACE AMOUNT OF COVERAGE [If not known, PREMIUM FOR MODE QUOTED]
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The planned period premium is _____ The frequency to be paid is _____

LEAVE WITH APPLICANT

Guaranteed Cash Value: If you continuously pay your premiums on this policy as they become due, you will have the following guaranteed cash surrender value for each $1,000 of Face Amount. You may borrow against this cash value at an annual **8.0%** loan interest rate.

Number of years Policy has been in force	Cash Value per $1,000 (of total Face Amount)
5	
10	
20	
Age 65	

A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

The prospective insured ☐ ***has*** ☐ ***has not*** requested an early delivery of the index (check appropriate box). Upon request, either the Company or Agent will furnish you with additional information about the insurance described.

APPLICANT CERTIFICATION

The undersigned does hereby certify that the written disclosure statement was given no later than the time that the application was signed by the Applicant.

_____ _____

Signature of Applicant Date

_____

Print or Type Name

American Retirement Life Insurance Company®
Home Office: 1300 East Ninth Street, Cleveland, OH 44114
Administrative Office: PO Box 559015, Austin, TX 78755-9015
Customer Service: 866-459-4272

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

You have indicated that you intend to replace your existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under the existing policy, the period of time during which the issuing company could contest the policy because of (a) a material misrepresentation or omission concerning the medical information requested in your application or (b) deny coverage for death caused by suicide may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that, in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy, thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it, and have found it acceptable to you.

_____ _____
Applicant's Signature **Date**

_____ _____
Agent's Signature **Date**

_____
Existing Insurer

American Retirement Life Insurance Company®
Home Office: 1300 East Ninth Street, Cleveland, OH 44114
Administrative Office: PO Box 559015, Austin, TX 78755-9015
Customer Service: 866-459-4272

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You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

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After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it, and have found it acceptable to you.

_____ _____
Applicant's Signature **Date**

_____ _____
Agent's Signature **Date**

_____
Existing Insurer

Cigna Medicare Supplement Solutions®
Insured by American Retirement Life Insurance Company

Application Booklet for PENNSYLVANIA

MEDICARE SUPPLEMENT *and* LIFE INSURANCE

- APPLICATION
- SUPPLEMENTARY APPLICATION
- ELECTRONIC FUNDS TRANSFER AGREEMENT
- MIB PRE-NOTICE
- HIPAA NOTICES
- MED SUPP REPLACEMENT NOTICE

REQUIRED WHEN APPLYING FOR LIFE INSURANCE

- NOTICE AND CUSTOMER INFORMATION FORM
- ACCELERATED BENEFIT TERMINAL ILLNESS DISCLOSURE
- DISCLOSURE STATEMENT
- LIFE REPLACEMENT NOTICE

Note: All Applications outside of OE/GI require a Phone Verification (PV) – Reduce delays and make the PV call at the point-of-sale. **Call our PV Hotline at 866.825.4822 from 8 a.m. to 6 p.m. Central Time.**

GO YOU®

Cigna®

AMERICAN RETIREMENT LIFE INSURANCE COMPANY

11200 Lakeline Blvd., Suite 100, Austin, TX 78717
Mailing address: PO Box 559015, Austin, TX 78755-9015

Medicare Supplement Insurance and Whole Life Insurance Application

☐ NEW BUSINESS ☐ REINSTATEMENT **PV CASE #**_____

SECTION I: APPLICANT INFORMATION (PLEASE PRINT)

Name of Applicant First	MI	Last	Age	Date of Birth MM	DD	YYYY	State of Birth

Resident Street Address (no PO Box) _____

City _____ **State** _____ **Zip** _____

Mailing Address (if different from above) _____

City _____ **State** _____ **Zip** _____

Phone ( ) _____ **Email Address** _____

Social Security No.	Medicare Card No.	Sex M/F
– –		

Rate Class: ☐ Preferred ☐ Standard

SECTION II: BILLING

METHOD (select one of the following):
☐ Bank Draft (complete the EFT Agreement)
☐ Direct Bill

MODE (select one of the following):
☐ Monthly (n/a with Direct Bill) ☐ Quarterly
☐ Semi-annually ☐ Annually

SECTION III: MEDICARE SUPPLEMENT COVERAGE APPLIED FOR

Requested Effective Date _____ *(if no date, we will assign the 1st day of the month following the Application date)*

Application is for: ☐ Underwritten ☐ Disabled (underage) ☐ Open Enrollment* ☐ Guaranteed Issue*

Check plan selected: ☐ Plan A ☐ Plan B ☐ Plan F ☐ Plan G ☐ Plan N **Modal Premium** $_____

*please refer to form AR-MS-SA-APP-PA for definitions of Open Enrollment and Eligible Persons for Guaranteed Issue

SECTION IV: WHOLE LIFE COVERAGE APPLIED FOR

If you are in Open Enrollment or eligible for Guaranteed Issue for a Medicare Supplement policy and are applying for Whole Life Insurance, you must answer all of the questions in Section IX of the Application.

Requested Effective Date _____ *(if no date, we will assign the 1st day of the month following the Application date)*

Whole Life Insurance: Benefit Amount $_____

Policy Modal Premium* $_____
*Modal Premium includes a $36 annual policy fee

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship

Owner, if other than the Proposed Insured Name	Relationship	Social Security No.
		– –

Address _____

SECTION V: TOTAL PREMIUM WITH APPLICATION

Initial premium*: ☐ Draft bank account ☐ Check enclosed (payable to ***American Retirement Life Insurance Company)***
*initial premium payment must include the Medicare Supplement one-time application fee

Medicare Supplement Insurance Policy Modal Premium	$_____
Whole Life Insurance Policy Modal Premium	$_____
One-time Application Fee**	$ 20
Total Premium with Application	$_____

**this fee is refunded if the policy is not issued or is returned within 30 days of delivery

SECTION VI: OPEN ENROLLMENT / GUARANTEED ISSUE QUESTIONS (MUST BE COMPLETED)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS (mark YES or NO below with an "X").

To the best of your knowledge, **YES** **NO**

1) a) Did you turn age 65 in the last 6 months? ☐ ☐
   b) Did you enroll in Medicare Part B in the last 6 months? ☐ ☐
   If "YES", what is the effective date? _____

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 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 Medicare Part B premium? ☐ ☐

3) Have 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)? ☐ ☐
   If "YES",
   a) Fill in your "START" and "END" dates below (if you are still covered under this plan, leave "END" date blank): START _____ END _____
   b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ ☐
   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? ☐ ☐

4) a) Do you have another Medicare Supplement policy in force? ☐ ☐
   b) If so, with what company and what type plan do you have? _____
   _____
   c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ ☐
   If existing Medicare Supplement coverage is not to be replaced, this policy cannot be issued.

5) Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ☐ ☐
   a) If so, with what company and what kind of policy? _____
   _____
   b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave the "END" date blank.) START _____ END _____

SECTION VII: MEDICARE

1) Do you now have Medicare Parts A and B? **YES** ☐ **NO** ☐
   If "YES", give effective date of Part B _____

2) If Medicare Parts A and B are to be effective at a future date, provide the date both Medicare Parts A and B will be effective _____
   NOTE: Medicare effective date is always the 1st day of the month. Applicant must have both Medicare Parts A and B on the effective date of the policy. If not, coverage cannot be issued.

SECTION VIII: EXISTING COVERAGE & REPLACEMENT (IF APPLYING FOR WHOLE LIFE INSURANCE, PLEASE COMPLETE THIS SECTION)

1) Do you, the Applicant, have existing individual life insurance policies or individual annuity contracts with this or any other company? ..... **YES** ☐ **NO** ☐
If "YES", (a) the Applicant and Agent must complete the required "Important Notice: Replacement of Life Insurance or Annuities" form; (b) the Agent must complete the Section "Agent Provided Sales Material Statement" below and sign; and (c) provide the following information (use additional sheet, if needed):

Insurance Company Name and Address	Contract or Policy Number	Is Coverage being Replaced?
		YES ☐ NO ☐
		YES ☐ NO ☐

Applicant's Signature / Printed Name _____ Date _____

Agent's Signature / Printed Name _____ Date _____

2) **AGENT PROVIDED SALES MATERIAL STATEMENT** (MUST BE COMPLETED BY THE AGENT ONLY IF THE APPLICANT IS REPLACING EXISTING LIFE INSURANCE OR ANNUITY): I hereby certify that in connection with my presentation to the Applicant herein, I only used sales material that was previously approved by American Retirement Life Insurance Company and that I left with or provided to the Applicant a copy of the sales material used in my presentation to the Applicant.

Agent's Signature / Printed Name _____ Date _____

SECTION IX: MEDICAL QUESTIONS

PLEASE REFER TO FORM AR-MS-SA-APP-PA FOR DEFINITIONS OF OPEN ENROLLMENT AND ELIGIBLE PERSONS FOR GUARANTEED ISSUE. IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE (BASED ON YOUR ANSWERS IN SECTIONS VI & VII AND THE INFORMATION PROVIDED IN FORM AR-MS-SA-APP-PA), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.

It is important that you provide truthful and accurate answers to the questions in this section as your answers form the basis of our determination of your eligibility for this coverage. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage.

PART A: MEDICAL QUESTIONS - If the answer to any question in Part A is "YES", the Applicant is not eligible for coverage.

	YES	NO
1) Are you currently confined or scheduled for admission to a hospital, nursing facility, or assisted living facility or are you receiving home health care services?	☐	☐
2) Do you require or receive any assistance with bathing, transferring, toileting, eating, or dressing?	☐	☐
3) Are you currently bedridden or do you use the assistance of a wheelchair, walker, or motorized mobility aid?	☐	☐
4) Within the past two (2) years, have you:		
a) been diagnosed by a member of the medical profession with a terminal illness or been hospitalized more than two (2) times, received home health care services more than three (3) times, or been confined to a nursing facility for more than thirty (30) days?	☐	☐
b) been diagnosed with or treated (other than with maintenance medication) by a member of the medical profession for angina, heart attack, atrial fibrillation, cardiomyopathy, congestive heart failure, cardiac or vascular angioplasty, stent placement, peripheral vascular disease, coronary bypass, carotid artery disease, coronary artery disease, or heart disease; had heart or heart valve surgery or required the implantation of cardiac pacemaker or defibrillator?	☐	☐
c) had a stroke or Transient Ischemic Attack (TIA)?	☐	☐
5) Do you have now or in the last two (2) years have you received from a member of the medical profession advice or treatment, or been advised to have treatment or surgery, or taken medication for the following conditions:		
a) hepatitis (other than hepatitis A), cirrhosis of the liver, or other liver disease?	☐	☐
b) major depression, bipolar disorder, schizophrenia, or a paranoid disorder?	☐	☐
c) diabetes requiring more than 50 units of insulin daily to control or diabetes with any of the following: neuropathy, retinopathy, vascular disease, or hypertension requiring more than two medications to control?	☐	☐

	YES	NO
d) chronic kidney disease, Addison's Disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant?	☐	☐
e) internal cancer, leukemia, malignant melanoma, Hodgkin's Disease, or lymphoma?	☐	☐
f) alcohol or drug abuse?	☐	☐
g) paralysis, hemophilia, osteoporosis with fractures, or unrepaired aneurysm?	☐	☐
h) Paget's Disease, rheumatoid or disabling arthritis, systemic lupus, or other connective tissue disorder?	☐	☐
6) Do you have now or at any time have you received from a member of the medical profession advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions:		
a) Parkinson's Disease, myasthenia gravis, multiple or amyotrophic lateral sclerosis, Lou Gehrig's Disease, muscular dystrophy, cerebral palsy, dementia, senility, Alzheimer's Disease, or organic brain disorder?	☐	☐
b) emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic Obstructive Lung Disease (COLD), or any chronic lung or respiratory disorder requiring the use of oxygen?	☐	☐
c) amputation caused by disease or organ transplant other than corneas?	☐	☐
7) Have you ever been diagnosed with or received medical advice or treatment from a physician or an appropriately licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection?	☐	☐
8) Do you have now or in the last three (3) years have you received from a member of the medical profession advice or treatment, or been advised to have treatment or surgery, or taken medication for anemia requiring repeated blood transfusions, or any other blood disorder?	☐	☐
9) Has surgery been advised by a member of the medical profession but not performed or is any surgery anticipated, including but not limited to joint replacement or cataract surgery?	☐	☐
10) Have medical tests (other than mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only), treatment, or therapy been advised by a member of the medical profession but not performed?	☐	☐

SECTION IX: MEDICAL QUESTIONS (CONTINUED)

PART B: MEDICAL QUESTIONS - If the answer to any of the following questions is "YES", you might be eligible for coverage. Please provide complete details as requested below.

	YES	NO
11) Within the past two (2) years, have you been declined for Life, Health, or Supplemental Insurance? If "YES", please provide details including the date of the declination, the type of coverage applied for, and the reason for the declination here: _____ _____	☐	☐
12) Have you used tobacco within the last twelve (12) months?	☐	☐
13) Height (Ft.-In.) _____ Weight (Lbs.) _____		
14) In the past two (2) years, have you had PSA levels greater than 6.0 or been diagnosed by a member of the medical profession with dysplasia of the cervix classified as a level 3.0 or higher? If "YES", please provide details in the table below.	☐	☐

Test	Results	Diagnosis

15) Within the past two (2) years, have you taken any medication for any heart or vascular disease other than hypertension? If "YES" or if you are taking any medications, give complete details in Part C Medications.	☐	☐

PART C: MEDICATIONS

16) Please list any prescription medications taken or prescribed in the last two (2) years because you were medically diagnosed and/or advised to by a member of the medical profession.
If you are not taking any medications, please check here: ☐ I am not taking any medications.

Medication	Dates Taken	Condition Taken for

AGENT NOTES - Please provide any other information that you believe may assist in our underwriting determination:

_____

_____

_____

_____

SECTION X: IMPORTANT STATEMENTS FOR APPLICANT TO READ

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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).

I hereby apply to American Retirement Life Insurance Company for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) No agent has the authority to waive the answer to any questions on the Application; (2) No insurance will be effective until a) a policy has been issued by the Company and b) the initial premium has been paid; and (3) I have received the Outline of Medicare Supplement Coverage for the policy applied for, the required *Guide to Health Insurance for People with Medicare*, and the MIB Notice.

CAUTION: Please review your answers to the questions on the Application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

I ☐ ***grant*** ☐ ***do not grant*** my authorization to receive information or presentation of materials describing other insurance products.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

A recorded telephone interview may be used as part of the underwriting on your Application for Insurance.

Telephone Number ( ) _____ Best time to call _____

I understand that the Medicare Supplement policy applied for will not cover loss due to Preexisting Condition(s) unless the expense for that loss is incurred more than six (6) months after the effective date of coverage.

Applicant's Printed Name _____

Signature of Applicant _____ Date _____

SECTION XI: AGENT(S) CERTIFICATION

Agents shall list any health insurance policies they have sold to the Applicant.

1) List policies sold which are still in force (if this does not apply, state "NONE"): _____

2) List policies sold in the past five (5) years which are no longer in force (if this does not apply, state "NONE"):

	YES	NO
3) Have you reviewed the Application for correctness and omissions?	☐	☐

4) I certify that I have provided the Applicant with the following documents:

a) Application Packet (Phone Sales only) b) *A Guide to Health Insurance for People with Medicare*
c) Outline of Medicare Supplement Coverage d) MIB Notice
e) other _____

I further certify that I have delivered the documents to the Applicant (check all that apply; must select at least one):

☐ In person _____ date ☐ Mail _____ date

☐ Email _____ date ☐ Fax _____ date

☐ other (explain) _____ _____ date

	YES	NO
5) Was the Application completed by you in the Applicant's physical presence?	☐	☐
6) Was the Application completed by you over the phone?	☐	☐
7) Do you have knowledge or reason to believe the replacement of existing insurance may be involved?	☐	☐

If "YES", give name of Company, reason, and termination date _____

I certify that I have interviewed the Applicant, asked all of the questions as written on the Application, and I have truly and accurately recorded on the Application the information supplied to me by the Applicant.

Printed Name of 1st Licensed Agent	Signature of 1st Licensed Agent	Writing Number	Percentage
Printed Name of 2nd Licensed Agent	Signature of 2nd Licensed Agent	Writing Number	Percentage

AMERICAN RETIREMENT LIFE INSURANCE COMPANY®
PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

MEDICARE SUPPLEMENTARY APPLICATION

Definitions of Open Enrollment and Eligible Person for Guaranteed Issue

Open Enrollment - The individual is applying for coverage prior to or during the six-month period beginning with the first day of the first month in which the individual enrolled for benefits under Medicare Part B, then he/she is eligible for open enrollment. If not, but the individual has lost or is losing other coverage, then he/she may be eligible for guaranteed issue.

The following information can help the individual determine if the individual is eligible for Guaranteed Issue.

Eligible Persons for Guaranteed Issue - An eligible person is an individual described in any of the following paragraphs:

1) The individual is 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, or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates, or the plan ceases to provide health benefits to the individual because the individual leaves the plan.

2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan:
   i) The certification of the organization or plan has been terminated.
   ii) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.
   iii) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the HHS Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (when the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the Social Security Act), or the plan is terminated for all individuals within a residence area.
   iv) The individual demonstrates, in accordance with guidelines established by the HHS Secretary, that one of the following applies:
      A) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically-necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards.
      B) The organization or producer or other entity acting on the organization's behalf materially misrepresented the plan's provisions in marketing the plan to the individual.
   v) The individual meets such other exceptional conditions as the HHS Secretary may provide.

3) The individual's enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) and the individual is enrolled with one of the following:
   i) an eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost)
   ii) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999
   iii) an organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care pre-payment plan)
   iv) an organization under a Medicare Select policy

4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because one of the following applies:
   i) The insolvency of the issuer or bankruptcy of the non-issuer organization or of involuntary termination of coverage or enrollment under the policy;
   ii) The issuer of the policy substantially violated a material provision of the policy;
   iii) The issuer or a producer or other entity acting on the issuer's behalf materially misrepresented the policy's provisions in marketing the policy to the individual.

5) The individual was enrolled under a Medicare supplement policy and terminated enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1894 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or any Medicare Select policy, and the subsequent enrollment under this paragraph is terminated by the enrollee during the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act).

6) The individual, upon first becoming eligible for benefits under Part A, and enrolled in Part B, if eligible, of Medicare, enrolls in a Medicare Advantage plan under Part C of Medicare or with a PACE provider under section 1894 of the Social Security Act and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers out-patient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D with the application for a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high-deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with out-patient prescription drug coverage.

I acknowledge receipt of this Supplementary Application.

_____ _____

Signature of Applicant **Date**

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

AMERICAN RETIREMENT LIFE INSURANCE COMPANY® • PO BOX 559015 • AUSTIN, TX 78755-9015

Proposed Insured's Name		Policy Number (if available)
Financial Institution Name and Telephone Number		
Financial Institution Address		
9-digit Routing Number	Account Number	Requested Withdrawal Date (1st - 28th)

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

For Checking Account: Please tape a VOIDED check in this box.

For Savings Account: Please attach a letter from the bank stating the account and routing number of your savings account.

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to American Retirement Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize American Retirement Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event American Retirement Life Insurance Company mistakenly deposits funds into my account, I authorize American Retirement Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR AMERICAN RETIREMENT LIFE INSURANCE COMPANY: It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by American Retirement Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by American Retirement Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by American Retirement Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured) **Payor's Address**

Print name of Depositor (as it appears on account) **Signature of Depositor** **Date**

MIB, Inc., Pre-Notice

AMERICAN RETIREMENT LIFE INSURANCE COMPANY®
PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

Information regarding your insurability will be treated as confidential. American Retirement Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

American Retirement Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company®.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information. However, MIB, Inc., information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB, Inc.
4. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 26580, Austin, Texas 78755-0580.
6. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
7. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
8. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
9. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

_____

Applicant's Name	**Name of Applicant's Personal Representative, if applicable**
Applicant's Social Security Number	**Relationship of Personal Representative to the Applicant**
Signature of Applicant **Date**	**Signature of Personal Representative** **Date**
Signature of Company's Agent **Date**	

A signed copy of this form will be provided with the policy if issued and any other time upon request.

AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER'S PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES ("Authorization")

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company®, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization at any time, except to the extent that action has been taken by the Company in reliance on this Authorization, by sending a written revocation to the Company's Privacy Steward at PO Box 26580, Austin, Texas 78755-0580.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing this Authorization.
6. I understand that if the person or entity that receives my Protected Health Information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this Authorization is as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this Authorization. This Authorization will expire twenty-four (24) months from the date it is signed.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer's behalf:

_____

Consumer's Name	**Name of Consumer's Personal Representative, if applicable**
Signature of Consumer **Date**	**Relationship of Personal Representative to the Consumer**
Signature of Company's Agent **Date**	**Signature of Personal Representative** **Date**

A signed copy of this form will be provided to you.

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the American Retirement Life Insurance Company (ARLIC) with the application.

A copy of this form must also be left with the Applicant.

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

AMERICAN RETIREMENT LIFE INSURANCE COMPANY®
PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

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 ARLIC. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, OR BROKER:

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 coverage 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 drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage Plan – please explain reason for disenrollment _____
- ☐ other (please specify) _____

NOTE:

1) 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 note 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy 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 premiums 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 YOU WANT TO KEEP IT.

_____	_____
Agent's Signature	**Applicant's Signature**
_____	_____
Type or Print Name and Address of Agent/Broker	**Date**

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the American Retirement Life Insurance Company (ARLIC) with the application.

A copy of this form must also be left with the Applicant.

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

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PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

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 ARLIC. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, OR BROKER:

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 coverage 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 drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage Plan – please explain reason for disenrollment _____
- ☐ other (please specify) _____

NOTE:

1) 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 note 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy 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 premiums 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 YOU WANT TO KEEP IT.

_____	_____
Agent's Signature	**Applicant's Signature**
_____	_____
Type or Print Name and Address of Agent/Broker	**Date**

American Retirement Life Insurance Company®
PO Box 559015, Austin, TX 78755-9015 • 866-459-4272

Notice and Customer Information Form

To help the government fight the funding of terrorism and money laundering activities, Federal law requires us to obtain all relevant customer-related information necessary to run an effective anti-money laundering program.

What this means to you: When submitting an application/order ticket/request form, we ask that the producer obtain the client's name, street address, date of birth, tax identification number, and other customer-related information that will allow us to identify the customer and fulfill our obligations under Federal law. Picture documentation, such as a driver's license or other identifying documents, will be used to verify the information given at the time of the sale.

By acknowledging receipt of this Notice and Customer Information Form, the undersigned authorizes any law enforcement agency, public or private institution, information service bureau, or other entity contacted by the Company identified above to furnish information sufficient to confirm the personal information of the undersigned as required by Federal law. This information is confidential and will not be used for any other purpose. The undersigned hereby releases all persons, agents and agencies, and entities providing confirming information from any and all liability arising out of the request for or the release of confirming information.

The owner information section must be completed in its entirety. If identification documents are not available, the customer must sign the form and the information will be verified by the Company.

The following information must be obtained for each tax identification number or social security number disclosed on the application for insurance.

I. **Owner**

FEIN/SSN	**Owner Name**	**Verification of ID** ☐ Driver's License/State ID ☐ Passport ☐ Other _____ ☐ Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)	**State/Country**	
Date of Birth	**Occupation**		**Number**	
Employer			**Date Issued**	**Exp. Date**

Additional Owner

FEIN/SSN	**Person's Name**	**Verification of ID** ☐ Driver's License/State ID ☐ Passport ☐ Other _____ ☐ Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)	**State/Country**	
Date of Birth	**Occupation**		**Number**	
Employer			**Date Issued**	**Exp. Date**

II. The source of funds for this transaction is _____

III. The purpose of this transaction is _____

Agent: I have examined and verified the customer's ID as noted above is true and correct to the best of my knowledge and belief.

_____ Agent's Printed Name

_____ Agent Number

_____ Agent's Signature

_____ Date

---------- **COMPLETE THIS PORTION ONLY IF THE APPLICANT DOES NOT HAVE IDENTIFICATION DOCUMENTS** ----------

Customer(s): I acknowledge the foregoing notice and certify that the foregoing information is true and correct to the best of my knowledge and belief.

_____ Owner's Printed Name

_____ Owner's Signature Date

_____ Additional Owner's Printed Name

_____ Additional Owner's Signature Date

American Retirement Life Insurance Company®
(Hereinafter called: the Company, We, Our, or Us)
Home Office: 1300 East Ninth Street, Cleveland, OH 44114
Administrative Office: PO Box 559015, Austin, TX 78755-9015
Customer Service: 866-459-4272

ACCELERATED BENEFIT TERMINAL ILLNESS RIDER DISCLOSURE STATEMENT

AN ACCELERATED BENEFIT THAT IS PAID ON ACCOUNT OF THIS RIDER WILL REDUCE THE DEATH BENEFITS OF THE POLICY. SUCH PAYMENT WILL ALSO REDUCE THE CASH VALUE OR OTHER VALUES OF THE POLICY, IF ANY. SOME PART OR ALL OF SUCH A PAYMENT MAY BE TAXABLE. AS WITH ALL TAX MATTERS, A TAX ADVISOR SHOULD BE CONSULTED.

What is an accelerated benefit? An accelerated benefit is the payment of a part of the proceeds of your life insurance policy before the death of an Insured. ("You" and "Your" refer to the Owner of the policy to which this rider is attached.)

Who can qualify for an accelerated benefit? An accelerated benefit may be paid with respect to the Insured or any additional Insured. The accelerated benefit will be paid only one time for each Insured.

When can I receive an accelerated benefit? Payment may be made to the Owner when an Insured has been diagnosed with a medical condition that results in a life expectancy of 12 months or less.

How much of the proceeds can be paid as an accelerated benefit? An accelerated benefit is paid from the Present Value of the Eligible Proceeds of your policy. The Eligible Proceeds are the death benefits of the policy (or combined policies) less any decreasing term riders and level term riders that will terminate within one year. Subject to the minimums and maximums described below, you may choose how much of the Eligible Proceeds are to be paid as an accelerated benefit.

In order to receive an accelerated benefit, you must have a least $10,000 in Eligible Proceeds. The Eligible Proceeds that are to be paid as an accelerated benefit must be at least $5,000. You may combine all policies that you have in force with us to satisfy these minimums.

You may not have more than 50% of your Eligible Proceeds paid as an accelerated benefit. You may not have more than $200,000 of Eligible Proceeds paid as an accelerated benefit. These maximums apply to the total of all policies you have in force with us.

When proceeds are to be paid as an accelerated benefit, is there a reduction for early payment? Yes, the Eligible Proceeds that are to be paid as an accelerated benefit are reduced to present value. The present value calculation takes into account the premiums we would have expected to receive in the future had the accelerated benefit not been elected, as well as an administrative fee. This means the amount you receive will always be less than the Eligible Proceeds you choose to be accelerated.

What is the administrative fee when an accelerated benefit is to be paid? We may charge an administrative fee of up to $100 when an accelerated benefit is to be paid. This fee will be included as par to the present value calculation. We will notify you if an administrative fee is charged.

How is the accelerated benefit paid? You may choose to have the accelerated benefit paid to you in a lump sum or in equal monthly installments. The Limited Life Expectancy Option provides for 12 months of installments.

What if the Insured dies before all payments are made? If the Insured dies before all payments are made, the present value of future payments will be paid to the beneficiary in a lump sum.

How will the payment of an accelerated benefit affect my policy? After the payment of an accelerated benefit, your policy will remain in force for a reduced Face Amount. The policy proceeds and all policy values will be reduced by the percentage of the Eligible Proceeds you elect to accelerate. Policy values that will be reduced include:

(a) death benefit face amount;
(b) future policy premiums (excluding the policy fee);
(c) cash values, if any;
(d) amounts available under the Reduced Paid-Up Nonforfeiture Option; and
(e) policy loan amounts outstanding.

Any policy fees associated with the policy will not be reduced.

Here is an example of how an accelerated benefit affects a policy:

Death Benefit (Eligible Proceeds) $100,000
Maximum Accelerated Benefits $ 50,000

	Death Benefit (Eligible Proceeds)	Premium plus any policy fees	Cash Value
Before accelerated payment	$100,000	$1,000	$26,000
After accelerated payment	$ 50,000	$ 500	$13,000

Do I have to pay an additional premium if the Rider is added to my policy? No, there is no additional premium charged if you add the rider to your policy.

When does the Rider terminate? The rider will terminate on the date an accelerated benefit is paid, the date you sent the company a written request to terminate the rider, or the date the policy terminates.

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Additional Insured Date

_____ _____
Signature of Owner Date

_____ _____
Signature of Agent or Company Representative Date

American Retirement Life Insurance Company®
(Hereinafter called: the Company, We, Our, or Us)
Home Office: 1300 East Ninth Street, Cleveland, OH 44114
Administrative Office: PO Box 559015, Austin, TX 78755-9015
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ACCELERATED BENEFIT TERMINAL ILLNESS RIDER DISCLOSURE STATEMENT

AN ACCELERATED BENEFIT THAT IS PAID ON ACCOUNT OF THIS RIDER WILL REDUCE THE DEATH BENEFITS OF THE POLICY. SUCH PAYMENT WILL ALSO REDUCE THE CASH VALUE OR OTHER VALUES OF THE POLICY, IF ANY. SOME PART OR ALL OF SUCH A PAYMENT MAY BE TAXABLE. AS WITH ALL TAX MATTERS, A TAX ADVISOR SHOULD BE CONSULTED.

What is an accelerated benefit? An accelerated benefit is the payment of a part of the proceeds of your life insurance policy before the death of an Insured. ("You" and "Your" refer to the Owner of the policy to which this rider is attached.)

Who can qualify for an accelerated benefit? An accelerated benefit may be paid with respect to the Insured or any additional Insured. The accelerated benefit will be paid only one time for each Insured.

When can I receive an accelerated benefit? Payment may be made to the Owner when an Insured has been diagnosed with a medical condition that results in a life expectancy of 12 months or less.

How much of the proceeds can be paid as an accelerated benefit? An accelerated benefit is paid from the Present Value of the Eligible Proceeds of your policy. The Eligible Proceeds are the death benefits of the policy (or combined policies) less any decreasing term riders and level term riders that will terminate within one year. Subject to the minimums and maximums described below, you may choose how much of the Eligible Proceeds are to be paid as an accelerated benefit.

In order to receive an accelerated benefit, you must have a least $10,000 in Eligible Proceeds. The Eligible Proceeds that are to be paid as an accelerated benefit must be at least $5,000. You may combine all policies that you have in force with us to satisfy these minimums.

You may not have more than 50% of your Eligible Proceeds paid as an accelerated benefit. You may not have more than $200,000 of Eligible Proceeds paid as an accelerated benefit. These maximums apply to the total of all policies you have in force with us.

When proceeds are to be paid as an accelerated benefit, is there a reduction for early payment? Yes, the Eligible Proceeds that are to be paid as an accelerated benefit are reduced to present value. The present value calculation takes into account the premiums we would have expected to receive in the future had the accelerated benefit not been elected, as well as an administrative fee. This means the amount you receive will always be less than the Eligible Proceeds you choose to be accelerated.

What is the administrative fee when an accelerated benefit is to be paid? We may charge an administrative fee of up to $100 when an accelerated benefit is to be paid. This fee will be included as par to the present value calculation. We will notify you if an administrative fee is charged.

How is the accelerated benefit paid? You may choose to have the accelerated benefit paid to you in a lump sum or in equal monthly installments. The Limited Life Expectancy Option provides for 12 months of installments.

What if the Insured dies before all payments are made? If the Insured dies before all payments are made, the present value of future payments will be paid to the beneficiary in a lump sum.

How will the payment of an accelerated benefit affect my policy? After the payment of an accelerated benefit, your policy will remain in force for a reduced Face Amount. The policy proceeds and all policy values will be reduced by the percentage of the Eligible Proceeds you elect to accelerate. Policy values that will be reduced include:

(a) death benefit face amount;
(b) future policy premiums (excluding the policy fee);
(c) cash values, if any;
(d) amounts available under the Reduced Paid-Up Nonforfeiture Option; and
(e) policy loan amounts outstanding.

Any policy fees associated with the policy will not be reduced.

Here is an example of how an accelerated benefit affects a policy:

Death Benefit (Eligible Proceeds) $100,000
Maximum Accelerated Benefits $ 50,000

	Death Benefit (Eligible Proceeds)	Premium plus any policy fees	Cash Value
Before accelerated payment	$100,000	$1,000	$26,000
After accelerated payment	$ 50,000	$ 500	$13,000

Do I have to pay an additional premium if the Rider is added to my policy? No, there is no additional premium charged if you add the rider to your policy.

When does the Rider terminate? The rider will terminate on the date an accelerated benefit is paid, the date you sent the company a written request to terminate the rider, or the date the policy terminates.

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Additional Insured Date

_____ _____
Signature of Owner Date

_____ _____
Signature of Agent or Company Representative Date

American Retirement Life Insurance Company®
PO Box 559015, Austin, TX 78755-9015

DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE. THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured _____ **Age** _____ **Sex** _____

Name of Agent Preparing Disclosure _____

Home or Agency Address of Agent _____

Telephone Number of Agent _____

Insurer: American Retirement Life Insurance Company

Direct all correspondence to: American Retirement Life Insurance Company, PO Box 26580, Austin, TX 78755-9004

	DESCRIPTIVE TITLE OF COVERAGE	FACE AMOUNT OF COVERAGE [If not applicable, DESCRIPTIVE TITLE OF COVERAGE]	FACE AMOUNT OF COVERAGE [If not known, PREMIUM FOR MODE QUOTED]
Policy	Final Expense Whole Life Policy		
Supplemental Benefit(s) (built into Policy)	Accelerated Benefit Terminal Illness Rider	This Rider will provide either a lump sum benefit amount or periodic payments upon the first diagnosis of a qualifying event. There is no charge for this Rider prior to the time a benefit is paid.	**The cost is included in the premium for the policy.**

The Face Amount of coverage of the **Whole Life Policy** changes as follows: **The Face Amount of the policy remains level for the life of the insured as long as the policy remains in force for the Whole Life Policy**.

The planned period premium is _____ The frequency to be paid is _____

RETURN TO COMPANY

Guaranteed Cash Value: If you continuously pay your premiums on this policy as they become due, you will have the following guaranteed cash surrender value for each $1,000 of Face Amount. You may borrow against this cash value at an annual **8.0%** loan interest rate.

Number of years Policy has been in force	Cash Value per $1,000 (of total Face Amount)
5	
10	
20	
Age 65	

A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

The prospective insured ☐ ***has*** ☐ ***has not*** requested an early delivery of the index (check appropriate box). Upon request, either the Company or Agent will furnish you with additional information about the insurance described.

APPLICANT CERTIFICATION

The undersigned does hereby certify that the written disclosure statement was given no later than the time that the application was signed by the Applicant.

_____ _____

Signature of Applicant Date

_____

Print or Type Name

RETURN TO COMPANY

American Retirement Life Insurance Company®
PO Box 559015, Austin, TX 78755-9015

DISCLOSURE STATEMENT

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Name of Proposed Insured _____ **Age** _____ **Sex** _____

Name of Agent Preparing Disclosure _____

Home or Agency Address of Agent _____

Telephone Number of Agent _____

Insurer: American Retirement Life Insurance Company

Direct all correspondence to: American Retirement Life Insurance Company, PO Box 26580, Austin, TX 78755-9004

	DESCRIPTIVE TITLE OF COVERAGE	FACE AMOUNT OF COVERAGE [If not applicable, DESCRIPTIVE TITLE OF COVERAGE]	FACE AMOUNT OF COVERAGE [If not known, PREMIUM FOR MODE QUOTED]
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The planned period premium is _____ The frequency to be paid is _____

LEAVE WITH APPLICANT

Guaranteed Cash Value: If you continuously pay your premiums on this policy as they become due, you will have the following guaranteed cash surrender value for each $1,000 of Face Amount. You may borrow against this cash value at an annual **8.0%** loan interest rate.

Number of years Policy has been in force	Cash Value per $1,000 (of total Face Amount)
5	
10	
20	
Age 65	

A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

The prospective insured ☐ ***has*** ☐ ***has not*** requested an early delivery of the index (check appropriate box). Upon request, either the Company or Agent will furnish you with additional information about the insurance described.

APPLICANT CERTIFICATION

The undersigned does hereby certify that the written disclosure statement was given no later than the time that the application was signed by the Applicant.

_____ _____

Signature of Applicant Date

_____

Print or Type Name

American Retirement Life Insurance Company®
Home Office: 1300 East Ninth Street, Cleveland, OH 44114
Administrative Office: PO Box 559015, Austin, TX 78755-9015
Customer Service: 866-459-4272

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

You have indicated that you intend to replace your existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under the existing policy, the period of time during which the issuing company could contest the policy because of (a) a material misrepresentation or omission concerning the medical information requested in your application or (b) deny coverage for death caused by suicide may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that, in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy, thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it, and have found it acceptable to you.

_____ _____
Applicant's Signature **Date**

_____ _____
Agent's Signature **Date**

_____
Existing Insurer

American Retirement Life Insurance Company®
Home Office: 1300 East Ninth Street, Cleveland, OH 44114
Administrative Office: PO Box 559015, Austin, TX 78755-9015
Customer Service: 866-459-4272

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You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it, and have found it acceptable to you.

_____ _____
Applicant's Signature **Date**

_____ _____
Agent's Signature **Date**

_____
Existing Insurer

AMERICAN RETIREMENT LIFE INSURANCE COMPANY

P. O. BOX 26580 ♦ AUSTIN, TX 78755-0580 ♦ 866-459-4272

Outline of Medicare Supplement Coverage - Benefit Plans A, B, F, G and N

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A", "B" and "C" or "F" available. Some plans may not be available in your state.

BASIC BENEFITS:

- Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
- Blood: First three pints of blood each year.
- Hospice: Part A coinsurance.

A	B	C	D	F / F*	G	K	L	M	N
Basic, Including 100% Part B Coinsurance	Basic, Including 100% Part B Coinsurance	Basic, Including 100% Part B Coinsurance	Basic, Including 100% Part B Coinsurance	Basic, Including 100% Part B Coinsurance*	Basic, Including 100% Part B Coinsurance	Hospitalization and Preventive Care Paid at 100%; Other Basic Benefits paid at 50%	Hospitalization and Preventive Care Paid at 100%; Other Basic Benefits Paid at 75%	Basic, Including 100% Part B Coinsurance	Basic, Including 100% Part B Coinsurance, Except Up to $20 Copayment for Office Visit, and up to $50 Copayment for ER Visit
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-Pocket Limit $4,940; Paid at 100% After Reached	Out-of-Pocket Limit $2,470; Paid At 100% After Reached		

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,140 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,140. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

PENNSYLVANIA

Attained Age Rates -- Effective 5/1/2014 -- Area I (155, 157-188, 195-196)

PREFERRED ANNUAL RATES

FEMALE RATES						MALE RATES				
Plan A	**Plan B**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan B**	**Plan F**	**Plan G**	**Plan N**
1,258.96	1,331.40	1,551.43	1,335.03	1,063.13	**Under 65 OE**	1,447.80	1,531.11	1,784.14	1,535.28	1,222.60
2,997.95	3,397.17	4,304.53	3,895.53	3,213.25	**Under 65 UW**	3,447.64	3,906.74	4,950.22	4,479.85	3,695.23
1,258.96	1,331.40	1,551.43	1,335.03	1,063.13	**65**	1,447.80	1,531.11	1,784.14	1,535.28	1,222.60
1,258.96	1,331.40	1,551.43	1,335.03	1,063.13	**66**	1,447.80	1,531.11	1,784.14	1,535.28	1,222.60
1,315.62	1,391.83	1,619.03	1,400.00	1,113.02	**67**	1,512.97	1,600.60	1,861.89	1,610.00	1,279.98
1,371.63	1,452.10	1,683.59	1,462.02	1,161.37	**68**	1,577.38	1,669.92	1,936.13	1,681.33	1,335.57
1,426.65	1,511.97	1,749.64	1,525.50	1,209.73	**69**	1,640.65	1,738.76	2,012.09	1,754.33	1,391.19
1,479.91	1,566.82	1,811.03	1,584.49	1,255.27	**70**	1,701.90	1,801.85	2,082.68	1,822.16	1,443.57
1,524.14	1,618.06	1,870.32	1,641.46	1,301.03	**71**	1,752.76	1,860.77	2,150.87	1,887.69	1,496.18
1,568.38	1,669.30	1,929.61	1,698.45	1,346.77	**72**	1,803.63	1,919.69	2,219.06	1,953.21	1,548.79
1,612.61	1,720.54	1,988.91	1,755.42	1,392.52	**73**	1,854.51	1,978.62	2,287.24	2,018.74	1,601.39
1,656.85	1,771.76	2,048.21	1,812.40	1,438.26	**74**	1,905.37	2,037.54	2,355.44	2,084.26	1,654.00
1,702.79	1,824.82	2,109.60	1,871.25	1,485.50	**75**	1,958.20	2,098.54	2,426.04	2,151.94	1,708.31
1,742.42	1,874.59	2,173.08	1,930.68	1,535.24	**76**	2,003.78	2,155.78	2,499.03	2,220.28	1,765.53
1,782.68	1,925.17	2,237.60	1,991.10	1,585.83	**77**	2,050.09	2,213.94	2,573.24	2,289.77	1,823.71
1,825.39	1,978.53	2,305.48	2,054.59	1,638.90	**78**	2,099.20	2,275.31	2,651.30	2,362.77	1,884.74
1,868.81	2,032.83	2,374.57	2,119.21	1,692.95	**79**	2,149.13	2,337.75	2,730.77	2,437.10	1,946.90
1,912.97	2,088.09	2,444.91	2,185.02	1,747.99	**80**	2,199.92	2,401.30	2,811.66	2,512.78	2,010.19
1,962.57	2,150.38	2,531.46	2,265.39	1,817.20	**81**	2,256.96	2,472.93	2,911.18	2,605.19	2,089.78
2,013.10	2,213.87	2,619.73	2,347.36	1,887.82	**82**	2,315.06	2,545.94	3,012.69	2,699.46	2,170.99
2,066.58	2,280.81	2,712.44	2,433.38	1,961.81	**83**	2,376.57	2,622.94	3,119.30	2,798.38	2,256.07
2,121.13	2,349.13	2,807.10	2,521.24	2,037.40	**84**	2,439.29	2,701.50	3,228.17	2,899.41	2,343.01
2,176.74	2,418.84	2,903.77	2,610.97	2,114.63	**85**	2,503.24	2,781.67	3,339.34	3,002.61	2,431.82
2,236.15	2,490.28	3,005.75	2,704.84	2,195.02	**86**	2,571.57	2,863.83	3,456.62	3,110.56	2,524.27
2,297.00	2,563.52	3,110.47	2,801.25	2,277.62	**87**	2,641.54	2,948.05	3,577.03	3,221.44	2,619.26
2,359.31	2,638.58	3,217.97	2,900.26	2,362.49	**88**	2,713.21	3,034.36	3,700.66	3,335.29	2,716.86
2,420.75	2,712.85	3,325.07	2,998.97	2,447.26	**89**	2,783.86	3,119.77	3,823.83	3,448.82	2,814.35
2,481.14	2,786.13	3,431.50	3,097.15	2,531.75	**90**	2,853.32	3,204.05	3,946.23	3,561.73	2,911.50
2,539.88	2,857.51	3,540.68	3,197.52	2,618.89	**91**	2,920.87	3,286.14	4,071.78	3,677.16	3,011.72
2,599.74	2,930.28	3,652.12	3,299.99	2,707.87	**92**	2,989.69	3,369.82	4,199.93	3,794.99	3,114.06
2,655.45	2,998.52	3,758.41	3,397.85	2,793.21	**93**	3,053.77	3,448.30	4,322.18	3,907.53	3,212.19
2,712.09	3,067.91	3,866.61	3,497.46	2,880.09	**94**	3,118.90	3,528.09	4,446.60	4,022.09	3,312.10
2,769.64	3,138.46	3,976.73	3,598.87	2,968.55	**95**	3,185.10	3,609.23	4,573.24	4,138.69	3,413.83
2,825.04	3,201.23	4,056.27	3,670.84	3,027.91	**96**	3,248.79	3,681.41	4,664.70	4,221.46	3,482.10
2,881.54	3,265.25	4,137.39	3,744.26	3,088.47	**97**	3,313.77	3,755.04	4,757.99	4,305.90	3,551.75
2,939.17	3,330.56	4,220.14	3,819.14	3,150.24	**98**	3,380.04	3,830.14	4,853.16	4,392.01	3,622.78
2,997.95	3,397.17	4,304.53	3,895.53	3,213.25	**99**	3,447.64	3,906.74	4,950.22	4,479.85	3,695.23

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted premium by 0.52, for quarterly premiums, multiply the above quoted premium by 0.265, and for monthly bank draft premiums, multiply the above-quoted premium by 0.0833.
During open enrollment and guaranteed issue periods preferred rates will apply.
Add one-time application fee of $20.00 to the first premium.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

PENNSYLVANIA

Attained Age Rates -- Effective 5/1/2014 -- Area I (155, 157-188, 195-196)

PREFERRED MONTHLY BANK DRAFT RATES

FEMALE RATES						MALE RATES				
Plan A	**Plan B**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan B**	**Plan F**	**Plan G**	**Plan N**
104.87	110.91	129.23	111.21	88.56	**Under 65 OE**	120.60	127.54	148.62	127.89	101.84
249.73	282.98	358.57	324.50	267.66	**Under 65 UW**	287.19	325.43	412.35	373.17	307.81
104.87	110.91	129.23	111.21	88.56	**65**	120.60	127.54	148.62	127.89	101.84
104.87	110.91	129.23	111.21	88.56	**66**	120.60	127.54	148.62	127.89	101.84
109.59	115.94	134.87	116.62	92.71	**67**	126.03	133.33	155.10	134.11	106.62
114.26	120.96	140.24	121.79	96.74	**68**	131.40	139.10	161.28	140.05	111.25
118.84	125.95	145.75	127.07	100.77	**69**	136.67	144.84	167.61	146.14	115.89
123.28	130.52	150.86	131.99	104.56	**70**	141.77	150.09	173.49	151.79	120.25
126.96	134.78	155.80	136.73	108.38	**71**	146.00	155.00	179.17	157.24	124.63
130.65	139.05	160.74	141.48	112.19	**72**	150.24	159.91	184.85	162.70	129.01
134.33	143.32	165.68	146.23	116.00	**73**	154.48	164.82	190.53	168.16	133.40
138.02	147.59	170.62	150.97	119.81	**74**	158.72	169.73	196.21	173.62	137.78
141.84	152.01	175.73	155.88	123.74	**75**	163.12	174.81	202.09	179.26	142.30
145.14	156.15	181.02	160.83	127.89	**76**	166.91	179.58	208.17	184.95	147.07
148.50	160.37	186.39	165.86	132.10	**77**	170.77	184.42	214.35	190.74	151.92
152.05	164.81	192.05	171.15	136.52	**78**	174.86	189.53	220.85	196.82	157.00
155.67	169.33	197.80	176.53	141.02	**79**	179.02	194.73	227.47	203.01	162.18
159.35	173.94	203.66	182.01	145.61	**80**	183.25	200.03	234.21	209.31	167.45
163.48	179.13	210.87	188.71	151.37	**81**	188.00	206.00	242.50	217.01	174.08
167.69	184.42	218.22	195.54	157.26	**82**	192.84	212.08	250.96	224.87	180.84
172.15	189.99	225.95	202.70	163.42	**83**	197.97	218.49	259.84	233.11	187.93
176.69	195.68	233.83	210.02	169.72	**84**	203.19	225.03	268.91	241.52	195.17
181.32	201.49	241.88	217.49	176.15	**85**	208.52	231.71	278.17	250.12	202.57
186.27	207.44	250.38	225.31	182.85	**86**	214.21	238.56	287.94	259.11	210.27
191.34	213.54	259.10	233.34	189.73	**87**	220.04	245.57	297.97	268.35	218.18
196.53	219.79	268.06	241.59	196.80	**88**	226.01	252.76	308.26	277.83	226.31
201.65	225.98	276.98	249.81	203.86	**89**	231.90	259.88	318.53	287.29	234.44
206.68	232.08	285.84	257.99	210.89	**90**	237.68	266.90	328.72	296.69	242.53
211.57	238.03	294.94	266.35	218.15	**91**	243.31	273.74	339.18	306.31	250.88
216.56	244.09	304.22	274.89	225.57	**92**	249.04	280.71	349.85	316.12	259.40
221.20	249.78	313.08	283.04	232.67	**93**	254.38	287.24	360.04	325.50	267.58
225.92	255.56	322.09	291.34	239.91	**94**	259.80	293.89	370.40	335.04	275.90
230.71	261.43	331.26	299.79	247.28	**95**	265.32	300.65	380.95	344.75	284.37
235.33	266.66	337.89	305.78	252.22	**96**	270.62	306.66	388.57	351.65	290.06
240.03	272.00	344.64	311.90	257.27	**97**	276.04	312.79	396.34	358.68	295.86
244.83	277.44	351.54	318.13	262.41	**98**	281.56	319.05	404.27	365.85	301.78
249.73	282.98	358.57	324.50	267.66	**99**	287.19	325.43	412.35	373.17	307.81

During open enrollment and guaranteed issue periods preferred rates will apply.

Add one-time enrollment fee of $20.00 to the first premium.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

PENNSYLVANIA

Attained Age Rates -- Effective 5/1/2014 -- Area I (155, 157-188, 195-196)

STANDARD ANNUAL RATES

FEMALE RATES						MALE RATES				
Plan A	**Plan B**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan B**	**Plan F**	**Plan G**	**Plan N**
3,297.75	3,736.88	4,735.00	4,285.08	3,534.57	**Under 65 UW**	3,792.41	4,297.42	5,445.24	4,927.84	4,064.75
1,384.85	1,464.54	1,706.57	1,468.53	1,169.45	**65**	1,592.57	1,684.22	1,962.56	1,688.81	1,344.87
1,384.85	1,464.54	1,706.57	1,468.53	1,169.45	**66**	1,592.57	1,684.22	1,962.56	1,688.81	1,344.87
1,447.18	1,531.01	1,780.95	1,539.99	1,224.33	**67**	1,664.26	1,760.66	2,048.09	1,771.00	1,407.97
1,508.79	1,597.32	1,851.95	1,608.23	1,277.51	**68**	1,735.11	1,836.92	2,129.74	1,849.46	1,469.13
1,569.31	1,663.17	1,924.61	1,678.05	1,330.71	**69**	1,804.71	1,912.63	2,213.29	1,929.76	1,530.31
1,627.89	1,723.51	1,992.13	1,742.93	1,380.81	**70**	1,872.09	1,982.03	2,290.95	2,004.38	1,587.93
1,676.56	1,779.87	2,057.35	1,805.61	1,431.13	**71**	1,928.04	2,046.85	2,365.96	2,076.45	1,645.79
1,725.21	1,836.23	2,122.58	1,868.29	1,481.44	**72**	1,984.00	2,111.66	2,440.97	2,148.53	1,703.66
1,773.88	1,892.59	2,187.80	1,930.97	1,531.77	**73**	2,039.95	2,176.47	2,515.98	2,220.61	1,761.53
1,822.53	1,948.94	2,253.03	1,993.64	1,582.09	**74**	2,095.91	2,241.29	2,590.98	2,292.68	1,819.40
1,873.06	2,007.31	2,320.56	2,058.38	1,634.04	**75**	2,154.02	2,308.40	2,668.65	2,367.13	1,879.15
1,916.67	2,062.05	2,390.38	2,123.74	1,688.76	**76**	2,204.17	2,371.36	2,748.94	2,442.31	1,942.08
1,960.95	2,117.69	2,461.36	2,190.22	1,744.41	**77**	2,255.10	2,435.34	2,830.56	2,518.75	2,006.08
2,007.92	2,176.39	2,536.02	2,260.04	1,802.79	**78**	2,309.11	2,502.84	2,916.43	2,599.05	2,073.22
2,055.69	2,236.11	2,612.04	2,331.14	1,862.24	**79**	2,364.04	2,571.53	3,003.85	2,680.81	2,141.59
2,104.27	2,296.90	2,689.42	2,403.53	1,922.80	**80**	2,419.90	2,641.43	3,092.82	2,764.05	2,211.21
2,158.83	2,365.42	2,784.61	2,491.92	1,998.93	**81**	2,482.66	2,720.23	3,202.31	2,865.71	2,298.76
2,214.41	2,435.25	2,881.71	2,582.09	2,076.60	**82**	2,546.56	2,800.54	3,313.97	2,969.40	2,388.09
2,273.24	2,508.89	2,983.68	2,676.71	2,157.99	**83**	2,614.23	2,885.23	3,431.23	3,078.22	2,481.68
2,333.23	2,584.04	3,087.82	2,773.36	2,241.14	**84**	2,683.22	2,971.65	3,550.98	3,189.36	2,577.31
2,394.41	2,660.72	3,194.16	2,872.05	2,326.09	**85**	2,753.57	3,059.83	3,673.27	3,302.86	2,675.00
2,459.76	2,739.31	3,306.34	2,975.32	2,414.52	**86**	2,828.73	3,150.21	3,802.28	3,421.62	2,776.70
2,526.70	2,819.86	3,421.51	3,081.37	2,505.38	**87**	2,905.70	3,242.84	3,934.74	3,543.59	2,881.19
2,595.25	2,902.44	3,539.77	3,190.28	2,598.73	**88**	2,984.53	3,337.80	4,070.73	3,668.83	2,988.54
2,662.83	2,984.13	3,657.58	3,298.86	2,691.99	**89**	3,062.25	3,431.75	4,206.22	3,793.70	3,095.79
2,729.26	3,064.75	3,774.66	3,406.86	2,784.92	**90**	3,138.65	3,524.45	4,340.86	3,917.90	3,202.65
2,793.88	3,143.26	3,894.75	3,517.27	2,880.77	**91**	3,212.96	3,614.75	4,478.96	4,044.87	3,312.90
2,859.71	3,223.30	4,017.33	3,629.98	2,978.67	**92**	3,288.66	3,706.80	4,619.93	4,174.49	3,425.46
2,921.00	3,298.37	4,134.26	3,737.63	3,072.52	**93**	3,359.15	3,793.13	4,754.40	4,298.28	3,533.40
2,983.30	3,374.70	4,253.27	3,847.21	3,168.10	**94**	3,430.79	3,880.90	4,891.26	4,424.29	3,643.31
3,046.61	3,452.31	4,374.40	3,958.74	3,265.40	**95**	3,503.60	3,970.15	5,030.56	4,552.56	3,755.20
3,107.55	3,521.35	4,461.89	4,037.92	3,330.71	**96**	3,573.68	4,049.55	5,131.17	4,643.61	3,830.31
3,169.70	3,591.78	4,551.13	4,118.68	3,397.32	**97**	3,645.15	4,130.54	5,233.80	4,736.49	3,906.91
3,233.08	3,663.61	4,642.15	4,201.05	3,465.27	**98**	3,718.05	4,213.15	5,338.47	4,831.21	3,985.06
3,297.75	3,736.88	4,735.00	4,285.08	3,534.57	**99**	3,792.41	4,297.42	5,445.24	4,927.84	4,064.75

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted premium by 0.52, for quarterly premiums, multiply the above quoted premium by 0.265, and for monthly bank draft premiums, multiply the above-quoted premium by 0.0833.
During open enrollment and guaranteed issue periods preferred rates will apply.
Add one-time application fee of $20.00 to the first premium.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

PENNSYLVANIA

Attained Age Rates -- Effective 5/1/2014 -- Area I (155, 157-188, 195-196)

STANDARD MONTHLY BANK DRAFT RATES

FEMALE RATES						MALE RATES				
Plan A	**Plan B**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan B**	**Plan F**	**Plan G**	**Plan N**
274.70	311.28	394.43	356.95	294.43	**Under 65 UW**	315.91	357.98	453.59	410.49	338.59
115.36	122.00	142.16	122.33	97.42	**65**	132.66	140.30	163.48	140.68	112.03
115.36	122.00	142.16	122.33	97.42	**66**	132.66	140.30	163.48	140.68	112.03
120.55	127.53	148.35	128.28	101.99	**67**	138.63	146.66	170.61	147.52	117.28
125.68	133.06	154.27	133.97	106.42	**68**	144.53	153.02	177.41	154.06	122.38
130.72	138.54	160.32	139.78	110.85	**69**	150.33	159.32	184.37	160.75	127.47
135.60	143.57	165.94	145.19	115.02	**70**	155.95	165.10	190.84	166.96	132.27
139.66	148.26	171.38	150.41	119.21	**71**	160.61	170.50	197.08	172.97	137.09
143.71	152.96	176.81	155.63	123.40	**72**	165.27	175.90	203.33	178.97	141.91
147.76	157.65	182.24	160.85	127.60	**73**	169.93	181.30	209.58	184.98	146.74
151.82	162.35	187.68	166.07	131.79	**74**	174.59	186.70	215.83	190.98	151.56
156.03	167.21	193.30	171.46	136.12	**75**	179.43	192.29	222.30	197.18	156.53
159.66	171.77	199.12	176.91	140.67	**76**	183.61	197.53	228.99	203.44	161.78
163.35	176.40	205.03	182.45	145.31	**77**	187.85	202.86	235.79	209.81	167.11
167.26	181.29	211.25	188.26	150.17	**78**	192.35	208.49	242.94	216.50	172.70
171.24	186.27	217.58	194.18	155.12	**79**	196.92	214.21	250.22	223.31	178.39
175.29	191.33	224.03	200.21	160.17	**80**	201.58	220.03	257.63	230.25	184.19
179.83	197.04	231.96	207.58	166.51	**81**	206.81	226.60	266.75	238.71	191.49
184.46	202.86	240.05	215.09	172.98	**82**	212.13	233.28	276.05	247.35	198.93
189.36	208.99	248.54	222.97	179.76	**83**	217.77	240.34	285.82	256.42	206.72
194.36	215.25	257.22	231.02	186.69	**84**	223.51	247.54	295.80	265.67	214.69
199.45	221.64	266.07	239.24	193.76	**85**	229.37	254.88	305.98	275.13	222.83
204.90	228.18	275.42	247.84	201.13	**86**	235.63	262.41	316.73	285.02	231.30
210.47	234.89	285.01	256.68	208.70	**87**	242.04	270.13	327.76	295.18	240.00
216.18	241.77	294.86	265.75	216.47	**88**	248.61	278.04	339.09	305.61	248.95
221.81	248.58	304.68	274.80	224.24	**89**	255.09	285.86	350.38	316.02	257.88
227.35	255.29	314.43	283.79	231.98	**90**	261.45	293.59	361.59	326.36	266.78
232.73	261.83	324.43	292.99	239.97	**91**	267.64	301.11	373.10	336.94	275.96
238.21	268.50	334.64	302.38	248.12	**92**	273.95	308.78	384.84	347.74	285.34
243.32	274.75	344.38	311.34	255.94	**93**	279.82	315.97	396.04	358.05	294.33
248.51	281.11	354.30	320.47	263.90	**94**	285.78	323.28	407.44	368.54	303.49
253.78	287.58	364.39	329.76	272.01	**95**	291.85	330.71	419.05	379.23	312.81
258.86	293.33	371.68	336.36	277.45	**96**	297.69	337.33	427.43	386.81	319.06
264.04	299.20	379.11	343.09	283.00	**97**	303.64	344.07	435.98	394.55	325.45
269.32	305.18	386.69	349.95	288.66	**98**	309.71	350.96	444.69	402.44	331.96
274.70	311.28	394.43	356.95	294.43	**99**	315.91	357.98	453.59	410.49	338.59

During open enrollment and guaranteed issue periods preferred rates will apply.

Add one-time enrollment fee of $20.00 to the first premium.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

PENNSYLVANIA

Attained Age Rates -- Effective 5/1/2014 -- Area II (150-154, 156)

PREFERRED ANNUAL RATES

FEMALE RATES						MALE RATES				
Plan A	**Plan B**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan B**	**Plan F**	**Plan G**	**Plan N**
1,413.11	1,494.43	1,741.41	1,498.51	1,193.31	**Under 65 OE**	1,625.08	1,718.60	2,002.61	1,723.28	1,372.31
3,365.05	3,813.15	4,831.62	4,372.53	3,606.71	**Under 65 UW**	3,869.80	4,385.12	5,556.37	5,028.40	4,147.71
1,413.11	1,494.43	1,741.41	1,498.51	1,193.31	**65**	1,625.08	1,718.60	2,002.61	1,723.28	1,372.31
1,413.11	1,494.43	1,741.41	1,498.51	1,193.31	**66**	1,625.08	1,718.60	2,002.61	1,723.28	1,372.31
1,476.72	1,562.26	1,817.28	1,571.43	1,249.31	**67**	1,698.23	1,796.59	2,089.88	1,807.14	1,436.71
1,539.59	1,629.91	1,889.74	1,641.04	1,303.58	**68**	1,770.52	1,874.40	2,173.21	1,887.21	1,499.11
1,601.34	1,697.11	1,963.88	1,712.30	1,357.86	**69**	1,841.54	1,951.67	2,258.47	1,969.15	1,561.54
1,661.12	1,758.68	2,032.79	1,778.51	1,408.98	**70**	1,910.29	2,022.49	2,337.70	2,045.28	1,620.34
1,710.77	1,816.19	2,099.34	1,842.46	1,460.34	**71**	1,967.39	2,088.62	2,414.24	2,118.83	1,679.38
1,760.43	1,873.70	2,165.89	1,906.42	1,511.68	**72**	2,024.48	2,154.76	2,490.78	2,192.38	1,738.44
1,810.07	1,931.21	2,232.45	1,970.37	1,563.03	**73**	2,081.59	2,220.89	2,567.32	2,265.93	1,797.48
1,859.73	1,988.71	2,299.01	2,034.33	1,614.37	**74**	2,138.69	2,287.03	2,643.86	2,339.48	1,856.54
1,911.29	2,048.27	2,367.92	2,100.38	1,667.39	**75**	2,197.98	2,355.51	2,723.11	2,415.44	1,917.49
1,955.78	2,104.13	2,439.17	2,167.09	1,723.23	**76**	2,249.15	2,419.75	2,805.03	2,492.15	1,981.71
2,000.97	2,160.90	2,511.59	2,234.91	1,780.02	**77**	2,301.12	2,485.03	2,888.33	2,570.15	2,047.02
2,048.91	2,220.80	2,587.78	2,306.17	1,839.58	**78**	2,356.24	2,553.91	2,975.95	2,652.09	2,115.52
2,097.64	2,281.74	2,665.34	2,378.71	1,900.25	**79**	2,412.29	2,624.01	3,065.15	2,735.52	2,185.29
2,147.21	2,343.77	2,744.29	2,452.58	1,962.03	**80**	2,469.29	2,695.33	3,155.95	2,820.47	2,256.33
2,202.88	2,413.70	2,841.43	2,542.78	2,039.71	**81**	2,533.33	2,775.74	3,267.65	2,924.19	2,345.67
2,259.60	2,484.95	2,940.51	2,634.79	2,118.98	**82**	2,598.54	2,857.69	3,381.59	3,030.01	2,436.83
2,319.63	2,560.09	3,044.57	2,731.34	2,202.03	**83**	2,667.58	2,944.11	3,501.25	3,141.04	2,532.33
2,380.86	2,636.78	3,150.83	2,829.96	2,286.88	**84**	2,737.98	3,032.30	3,623.46	3,254.44	2,629.91
2,443.28	2,715.02	3,259.34	2,930.68	2,373.56	**85**	2,809.76	3,122.28	3,748.24	3,370.27	2,729.60
2,509.96	2,795.21	3,373.80	3,036.04	2,463.79	**86**	2,886.46	3,214.50	3,879.88	3,491.45	2,833.37
2,578.27	2,877.42	3,491.34	3,144.26	2,556.52	**87**	2,965.00	3,309.03	4,015.04	3,615.90	2,939.99
2,648.21	2,961.67	3,612.01	3,255.39	2,651.77	**88**	3,045.44	3,405.91	4,153.81	3,743.70	3,049.54
2,717.17	3,045.03	3,732.22	3,366.19	2,746.93	**89**	3,124.74	3,501.78	4,292.05	3,871.12	3,158.96
2,784.96	3,127.29	3,851.69	3,476.40	2,841.76	**90**	3,202.71	3,596.38	4,429.45	3,997.86	3,268.01
2,850.89	3,207.41	3,974.23	3,589.05	2,939.58	**91**	3,278.52	3,688.53	4,570.37	4,127.42	3,380.50
2,918.07	3,289.08	4,099.31	3,704.07	3,039.45	**92**	3,355.78	3,782.45	4,714.21	4,259.68	3,495.37
2,980.61	3,365.69	4,218.62	3,813.91	3,135.24	**93**	3,427.70	3,870.54	4,851.42	4,386.00	3,605.52
3,044.18	3,443.57	4,340.07	3,925.72	3,232.75	**94**	3,500.81	3,960.10	4,991.09	4,514.59	3,717.67
3,108.78	3,522.76	4,463.67	4,039.54	3,332.04	**95**	3,575.11	4,051.18	5,133.23	4,645.47	3,831.85
3,170.96	3,593.21	4,552.95	4,120.33	3,398.68	**96**	3,646.60	4,132.20	5,235.88	4,738.37	3,908.48
3,234.38	3,665.08	4,644.01	4,202.74	3,466.66	**97**	3,719.53	4,214.85	5,340.61	4,833.15	3,986.65
3,299.06	3,738.39	4,736.89	4,286.79	3,535.99	**98**	3,793.93	4,299.13	5,447.42	4,929.81	4,066.38
3,365.05	3,813.15	4,831.62	4,372.53	3,606.71	**99**	3,869.80	4,385.12	5,556.37	5,028.40	4,147.71

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted premium by 0.52, for quarterly premiums, multiply the above quoted premium by 0.265, and for monthly bank draft premiums, multiply the above-quoted premium by 0.0833.
During open enrollment and guaranteed issue periods preferred rates will apply.
Add one-time application fee of $20.00 to the first premium.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

PENNSYLVANIA

Attained Age Rates -- Effective 5/1/2014 -- Area II (150-154, 156)

PREFERRED MONTHLY BANK DRAFT RATES

FEMALE RATES						MALE RATES				
Plan A	**Plan B**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan B**	**Plan F**	**Plan G**	**Plan N**
117.71	124.49	145.06	124.83	99.40	**Under 65 OE**	135.37	143.16	166.82	143.55	114.31
280.31	317.64	402.47	364.23	300.44	**Under 65 UW**	322.35	365.28	462.85	418.87	345.50
117.71	124.49	145.06	124.83	99.40	**65**	135.37	143.16	166.82	143.55	114.31
117.71	124.49	145.06	124.83	99.40	**66**	135.37	143.16	166.82	143.55	114.31
123.01	130.14	151.38	130.90	104.07	**67**	141.46	149.66	174.09	150.53	119.68
128.25	135.77	157.42	136.70	108.59	**68**	147.48	156.14	181.03	157.20	124.88
133.39	141.37	163.59	142.63	113.11	**69**	153.40	162.57	188.13	164.03	130.08
138.37	146.50	169.33	148.15	117.37	**70**	159.13	168.47	194.73	170.37	134.97
142.51	151.29	174.88	153.48	121.65	**71**	163.88	173.98	201.11	176.50	139.89
146.64	156.08	180.42	158.80	125.92	**72**	168.64	179.49	207.48	182.63	144.81
150.78	160.87	185.96	164.13	130.20	**73**	173.40	185.00	213.86	188.75	149.73
154.92	165.66	191.51	169.46	134.48	**74**	178.15	190.51	220.23	194.88	154.65
159.21	170.62	197.25	174.96	138.89	**75**	183.09	196.21	226.84	201.21	159.73
162.92	175.27	203.18	180.52	143.55	**76**	187.35	201.57	233.66	207.60	165.08
166.68	180.00	209.22	186.17	148.28	**77**	191.68	207.00	240.60	214.09	170.52
170.67	184.99	215.56	192.10	153.24	**78**	196.27	212.74	247.90	220.92	176.22
174.73	190.07	222.02	198.15	158.29	**79**	200.94	218.58	255.33	227.87	182.03
178.86	195.24	228.60	204.30	163.44	**80**	205.69	224.52	262.89	234.95	187.95
183.50	201.06	236.69	211.81	169.91	**81**	211.03	231.22	272.20	243.59	195.39
188.22	207.00	244.94	219.48	176.51	**82**	216.46	238.05	281.69	252.40	202.99
193.23	213.26	253.61	227.52	183.43	**83**	222.21	245.24	291.65	261.65	210.94
198.33	219.64	262.46	235.74	190.50	**84**	228.07	252.59	301.83	271.09	219.07
203.53	226.16	271.50	244.13	197.72	**85**	234.05	260.09	312.23	280.74	227.38
209.08	232.84	281.04	252.90	205.23	**86**	240.44	267.77	323.19	290.84	236.02
214.77	239.69	290.83	261.92	212.96	**87**	246.98	275.64	334.45	301.20	244.90
220.60	246.71	300.88	271.17	220.89	**88**	253.69	283.71	346.01	311.85	254.03
226.34	253.65	310.89	280.40	228.82	**89**	260.29	291.70	357.53	322.46	263.14
231.99	260.50	320.85	289.58	236.72	**90**	266.79	299.58	368.97	333.02	272.23
237.48	267.18	331.05	298.97	244.87	**91**	273.10	307.25	380.71	343.81	281.60
243.08	273.98	341.47	308.55	253.19	**92**	279.54	315.08	392.69	354.83	291.16
248.28	280.36	351.41	317.70	261.17	**93**	285.53	322.42	404.12	365.35	300.34
253.58	286.85	361.53	327.01	269.29	**94**	291.62	329.88	415.76	376.07	309.68
258.96	293.45	371.82	336.49	277.56	**95**	297.81	337.46	427.60	386.97	319.19
264.14	299.31	379.26	343.22	283.11	**96**	303.76	344.21	436.15	394.71	325.58
269.42	305.30	386.85	350.09	288.77	**97**	309.84	351.10	444.87	402.60	332.09
274.81	311.41	394.58	357.09	294.55	**98**	316.03	358.12	453.77	410.65	338.73
280.31	317.64	402.47	364.23	300.44	**99**	322.35	365.28	462.85	418.87	345.50

During open enrollment and guaranteed issue periods preferred rates will apply.

Add one-time enrollment fee of $20.00 to the first premium.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

PENNSYLVANIA

Attained Age Rates -- Effective 5/1/2014 -- Area II (150-154, 156)

STANDARD ANNUAL RATES

FEMALE RATES						MALE RATES				
Plan A	**Plan B**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan B**	**Plan F**	**Plan G**	**Plan N**
3,701.56	4,194.46	5,314.79	4,809.78	3,967.37	**Under 65 UW**	4,256.78	4,823.64	6,112.00	5,531.24	4,562.48
1,554.43	1,643.87	1,915.54	1,648.35	1,312.64	**65**	1,787.58	1,890.45	2,202.87	1,895.61	1,509.54
1,554.43	1,643.87	1,915.54	1,648.35	1,312.64	**66**	1,787.58	1,890.45	2,202.87	1,895.61	1,509.54
1,624.39	1,718.48	1,999.02	1,728.56	1,374.24	**67**	1,868.05	1,976.25	2,298.88	1,987.86	1,580.37
1,693.54	1,792.91	2,078.71	1,805.15	1,433.94	**68**	1,947.57	2,061.85	2,390.53	2,075.92	1,649.03
1,761.47	1,866.82	2,160.27	1,883.53	1,493.65	**69**	2,025.69	2,146.83	2,484.31	2,166.06	1,717.69
1,827.23	1,934.55	2,236.07	1,956.35	1,549.89	**70**	2,101.32	2,224.73	2,571.47	2,249.81	1,782.37
1,881.85	1,997.81	2,309.27	2,026.70	1,606.37	**71**	2,164.13	2,297.49	2,655.67	2,330.71	1,847.32
1,936.46	2,061.07	2,382.49	2,097.06	1,662.84	**72**	2,226.94	2,370.23	2,739.86	2,411.62	1,912.28
1,991.09	2,124.33	2,455.69	2,167.41	1,719.33	**73**	2,289.74	2,442.98	2,824.05	2,492.52	1,977.22
2,045.70	2,187.58	2,528.91	2,237.76	1,775.81	**74**	2,352.55	2,515.73	2,908.25	2,573.42	2,042.18
2,102.42	2,253.10	2,604.71	2,310.42	1,834.13	**75**	2,417.78	2,591.06	2,995.42	2,656.99	2,109.25
2,151.36	2,314.54	2,683.07	2,383.79	1,895.55	**76**	2,474.07	2,661.73	3,085.54	2,741.37	2,179.88
2,201.07	2,377.00	2,762.75	2,458.41	1,958.01	**77**	2,531.24	2,733.54	3,177.16	2,827.17	2,251.72
2,253.79	2,442.88	2,846.55	2,536.78	2,023.54	**78**	2,591.86	2,809.31	3,273.55	2,917.30	2,327.08
2,307.40	2,509.92	2,931.88	2,616.58	2,090.27	**79**	2,653.52	2,886.41	3,371.66	3,009.07	2,403.82
2,361.93	2,578.15	3,018.73	2,697.84	2,158.24	**80**	2,716.22	2,964.87	3,471.54	3,102.51	2,481.97
2,423.18	2,655.06	3,125.58	2,797.05	2,243.69	**81**	2,786.66	3,053.31	3,594.42	3,216.62	2,580.24
2,485.56	2,733.45	3,234.57	2,898.27	2,330.88	**82**	2,858.39	3,143.46	3,719.76	3,333.01	2,680.51
2,551.60	2,816.11	3,349.03	3,004.48	2,422.24	**83**	2,934.34	3,238.52	3,851.38	3,455.14	2,785.56
2,618.93	2,900.45	3,465.92	3,112.95	2,515.57	**84**	3,011.78	3,335.52	3,985.80	3,579.90	2,892.90
2,687.60	2,986.53	3,585.28	3,223.73	2,610.92	**85**	3,090.74	3,434.51	4,123.06	3,707.30	3,002.55
2,760.96	3,074.73	3,711.19	3,339.65	2,710.17	**86**	3,175.11	3,535.95	4,267.87	3,840.59	3,116.71
2,836.09	3,165.15	3,840.47	3,458.68	2,812.16	**87**	3,261.50	3,639.93	4,416.54	3,977.50	3,233.99
2,913.04	3,257.84	3,973.21	3,580.93	2,916.94	**88**	3,349.98	3,746.51	4,569.19	4,118.07	3,354.48
2,988.89	3,349.53	4,105.44	3,702.81	3,021.62	**89**	3,437.22	3,851.96	4,721.27	4,258.23	3,474.86
3,063.46	3,440.02	4,236.86	3,824.03	3,125.93	**90**	3,522.98	3,956.02	4,872.39	4,397.64	3,594.82
3,135.99	3,528.15	4,371.66	3,947.96	3,233.52	**91**	3,606.39	4,057.38	5,027.40	4,540.16	3,718.56
3,209.88	3,617.99	4,509.24	4,074.47	3,343.40	**92**	3,691.35	4,160.70	5,185.63	4,685.65	3,844.90
3,278.68	3,702.25	4,640.49	4,195.30	3,448.75	**93**	3,770.47	4,257.59	5,336.57	4,824.60	3,966.07
3,348.60	3,787.93	4,774.07	4,318.30	3,556.03	**94**	3,850.89	4,356.11	5,490.19	4,966.04	4,089.43
3,419.67	3,875.04	4,910.04	4,443.49	3,665.24	**95**	3,932.61	4,456.29	5,646.55	5,110.02	4,215.02
3,488.06	3,952.54	5,008.24	4,532.36	3,738.55	**96**	4,011.27	4,545.42	5,759.47	5,212.22	4,299.32
3,557.82	4,031.58	5,108.41	4,623.01	3,813.31	**97**	4,091.50	4,636.32	5,874.67	5,316.47	4,385.31
3,628.97	4,112.21	5,210.58	4,715.47	3,889.58	**98**	4,173.33	4,729.05	5,992.17	5,422.79	4,473.02
3,701.56	4,194.46	5,314.79	4,809.78	3,967.37	**99**	4,256.78	4,823.64	6,112.00	5,531.24	4,562.48

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted premium by 0.52, for quarterly premiums, multiply the above quoted premium by 0.265, and for monthly bank draft premiums, multiply the above-quoted premium by 0.0833.
During open enrollment and guaranteed issue periods preferred rates will apply.
Add one-time application fee of $20.00 to the first premium.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

PENNSYLVANIA

Attained Age Rates -- Effective 5/1/2014 -- Area II (150-154, 156)

STANDARD MONTHLY BANK DRAFT RATES

FEMALE RATES						MALE RATES				
Plan A	**Plan B**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan B**	**Plan F**	**Plan G**	**Plan N**
308.34	349.40	442.72	400.65	330.48	**Under 65 UW**	354.59	401.81	509.13	460.75	380.05
129.48	136.93	159.56	137.31	109.34	**65**	148.91	157.47	183.50	157.90	125.74
129.48	136.93	159.56	137.31	109.34	**66**	148.91	157.47	183.50	157.90	125.74
135.31	143.15	166.52	143.99	114.47	**67**	155.61	164.62	191.50	165.59	131.64
141.07	149.35	173.16	150.37	119.45	**68**	162.23	171.75	199.13	172.92	137.36
146.73	155.51	179.95	156.90	124.42	**69**	168.74	178.83	206.94	180.43	143.08
152.21	161.15	186.26	162.96	129.11	**70**	175.04	185.32	214.20	187.41	148.47
156.76	166.42	192.36	168.82	133.81	**71**	180.27	191.38	221.22	194.15	153.88
161.31	171.69	198.46	174.69	138.51	**72**	185.50	197.44	228.23	200.89	159.29
165.86	176.96	204.56	180.55	143.22	**73**	190.74	203.50	235.24	207.63	164.70
170.41	182.23	210.66	186.41	147.92	**74**	195.97	209.56	242.26	214.37	170.11
175.13	187.68	216.97	192.46	152.78	**75**	201.40	215.84	249.52	221.33	175.70
179.21	192.80	223.50	198.57	157.90	**76**	206.09	221.72	257.03	228.36	181.58
183.35	198.00	230.14	204.79	163.10	**77**	210.85	227.70	264.66	235.50	187.57
187.74	203.49	237.12	211.31	168.56	**78**	215.90	234.02	272.69	243.01	193.85
192.21	209.08	244.23	217.96	174.12	**79**	221.04	240.44	280.86	250.66	200.24
196.75	214.76	251.46	224.73	179.78	**80**	226.26	246.97	289.18	258.44	206.75
201.85	221.17	260.36	232.99	186.90	**81**	232.13	254.34	299.42	267.94	214.93
207.05	227.70	269.44	241.43	194.16	**82**	238.10	261.85	309.86	277.64	223.29
212.55	234.58	278.97	250.27	201.77	**83**	244.43	269.77	320.82	287.81	232.04
218.16	241.61	288.71	259.31	209.55	**84**	250.88	277.85	332.02	298.21	240.98
223.88	248.78	298.65	268.54	217.49	**85**	257.46	286.09	343.45	308.82	250.11
229.99	256.13	309.14	278.19	225.76	**86**	264.49	294.54	355.51	319.92	259.62
236.25	263.66	319.91	288.11	234.25	**87**	271.68	303.21	367.90	331.33	269.39
242.66	271.38	330.97	298.29	242.98	**88**	279.05	312.08	380.61	343.04	279.43
248.97	279.02	341.98	308.44	251.70	**89**	286.32	320.87	393.28	354.71	289.46
255.19	286.55	352.93	318.54	260.39	**90**	293.46	329.54	405.87	366.32	299.45
261.23	293.89	364.16	328.87	269.35	**91**	300.41	337.98	418.78	378.20	309.76
267.38	301.38	375.62	339.40	278.51	**92**	307.49	346.59	431.96	390.31	320.28
273.11	308.40	386.55	349.47	287.28	**93**	314.08	354.66	444.54	401.89	330.37
278.94	315.53	397.68	359.71	296.22	**94**	320.78	362.86	457.33	413.67	340.65
284.86	322.79	409.01	370.14	305.31	**95**	327.59	371.21	470.36	425.66	351.11
290.56	329.25	417.19	377.55	311.42	**96**	334.14	378.63	479.76	434.18	358.13
296.37	335.83	425.53	385.10	317.65	**97**	340.82	386.21	489.36	442.86	365.30
302.29	342.55	434.04	392.80	324.00	**98**	347.64	393.93	499.15	451.72	372.60
308.34	349.40	442.72	400.65	330.48	**99**	354.59	401.81	509.13	460.75	380.05

During open enrollment and guaranteed issue periods preferred rates will apply.

Add one-time enrollment fee of $20.00 to the first premium.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

PENNSYLVANIA

Attained Age Rates -- Effective 5/1/2014 -- Area III (189-194)

PREFERRED ANNUAL RATES

FEMALE RATES						MALE RATES				
Plan A	**Plan B**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan B**	**Plan F**	**Plan G**	**Plan N**
1,541.58	1,630.29	1,899.72	1,634.74	1,301.79	**Under 65 OE**	1,772.81	1,874.83	2,184.67	1,879.94	1,497.06
3,670.96	4,159.80	5,270.86	4,770.03	3,934.59	**Under 65 UW**	4,221.60	4,783.77	6,061.50	5,485.53	4,524.78
1,541.58	1,630.29	1,899.72	1,634.74	1,301.79	**65**	1,772.81	1,874.83	2,184.67	1,879.94	1,497.06
1,541.58	1,630.29	1,899.72	1,634.74	1,301.79	**66**	1,772.81	1,874.83	2,184.67	1,879.94	1,497.06
1,610.97	1,704.28	1,982.49	1,714.28	1,362.89	**67**	1,852.62	1,959.91	2,279.87	1,971.42	1,567.32
1,679.55	1,778.09	2,061.53	1,790.23	1,422.09	**68**	1,931.48	2,044.80	2,370.77	2,058.77	1,635.40
1,746.92	1,851.39	2,142.42	1,867.96	1,481.30	**69**	2,008.96	2,129.09	2,463.79	2,148.16	1,703.50
1,812.13	1,918.56	2,217.59	1,940.19	1,537.07	**70**	2,083.96	2,206.35	2,550.22	2,231.22	1,767.64
1,866.29	1,981.30	2,290.19	2,009.95	1,593.10	**71**	2,146.24	2,278.50	2,633.72	2,311.45	1,832.05
1,920.46	2,044.04	2,362.79	2,079.73	1,649.11	**72**	2,208.53	2,350.65	2,717.22	2,391.69	1,896.48
1,974.62	2,106.78	2,435.40	2,149.49	1,705.12	**73**	2,270.83	2,422.79	2,800.71	2,471.93	1,960.89
2,028.80	2,169.50	2,508.01	2,219.27	1,761.13	**74**	2,333.11	2,494.94	2,884.21	2,552.16	2,025.31
2,085.04	2,234.47	2,583.19	2,291.33	1,818.97	**75**	2,397.79	2,569.64	2,970.67	2,635.03	2,091.81
2,133.58	2,295.41	2,660.91	2,364.10	1,879.89	**76**	2,453.61	2,639.73	3,060.04	2,718.71	2,161.87
2,182.88	2,357.35	2,739.91	2,438.09	1,941.84	**77**	2,510.31	2,710.95	3,150.90	2,803.81	2,233.11
2,235.17	2,422.69	2,823.04	2,515.82	2,006.82	**78**	2,570.45	2,786.09	3,246.49	2,893.19	2,307.84
2,288.33	2,489.18	2,907.64	2,594.95	2,073.00	**79**	2,631.59	2,862.55	3,343.80	2,984.21	2,383.95
2,342.42	2,556.84	2,993.77	2,675.54	2,140.40	**80**	2,693.77	2,940.36	3,442.85	3,076.87	2,461.45
2,403.15	2,633.12	3,099.75	2,773.95	2,225.14	**81**	2,763.63	3,028.08	3,564.71	3,190.03	2,558.91
2,465.02	2,710.86	3,207.83	2,874.32	2,311.61	**82**	2,834.77	3,117.48	3,689.01	3,305.46	2,658.36
2,530.50	2,792.83	3,321.35	2,979.65	2,402.21	**83**	2,910.09	3,211.76	3,819.55	3,426.59	2,762.54
2,597.30	2,876.48	3,437.26	3,087.23	2,494.77	**84**	2,986.89	3,307.96	3,952.86	3,550.30	2,868.99
2,665.39	2,961.84	3,555.64	3,197.10	2,589.34	**85**	3,065.20	3,406.12	4,088.98	3,676.66	2,977.74
2,738.14	3,049.32	3,680.51	3,312.04	2,687.77	**86**	3,148.87	3,506.73	4,232.59	3,808.85	3,090.95
2,812.66	3,139.00	3,808.74	3,430.10	2,788.93	**87**	3,234.54	3,609.85	4,380.04	3,944.62	3,207.26
2,888.95	3,230.92	3,940.37	3,551.34	2,892.84	**88**	3,322.30	3,715.54	4,531.43	4,084.03	3,326.77
2,964.19	3,321.86	4,071.51	3,672.20	2,996.65	**89**	3,408.80	3,820.13	4,682.24	4,223.04	3,446.14
3,038.14	3,411.59	4,201.84	3,792.43	3,100.10	**90**	3,493.86	3,923.33	4,832.12	4,361.30	3,565.10
3,110.06	3,498.99	4,335.52	3,915.33	3,206.81	**91**	3,576.57	4,023.85	4,985.85	4,502.64	3,687.82
3,183.35	3,588.09	4,471.98	4,040.80	3,315.76	**92**	3,660.85	4,126.31	5,142.77	4,646.92	3,813.13
3,251.57	3,671.66	4,602.13	4,160.63	3,420.26	**93**	3,739.31	4,222.41	5,292.46	4,784.73	3,933.30
3,320.92	3,756.62	4,734.62	4,282.61	3,526.64	**94**	3,819.07	4,320.11	5,444.82	4,925.01	4,055.64
3,391.40	3,843.02	4,869.46	4,406.78	3,634.96	**95**	3,900.12	4,419.46	5,599.89	5,067.79	4,180.20
3,459.23	3,919.87	4,966.86	4,494.90	3,707.65	**96**	3,978.11	4,507.85	5,711.87	5,169.13	4,263.80
3,528.41	3,998.26	5,066.19	4,584.81	3,781.81	**97**	4,057.67	4,598.01	5,826.12	5,272.53	4,349.08
3,598.98	4,078.24	5,167.51	4,676.50	3,857.44	**98**	4,138.83	4,689.96	5,942.64	5,377.97	4,436.05
3,670.96	4,159.80	5,270.86	4,770.03	3,934.59	**99**	4,221.60	4,783.77	6,061.50	5,485.53	4,524.78

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted premium by 0.52, for quarterly premiums, multiply the above quoted premium by 0.265, and for monthly bank draft premiums, multiply the above-quoted premium by 0.0833.
During open enrollment and guaranteed issue periods preferred rates will apply.
Add one-time application fee of $20.00 to the first premium.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

PENNSYLVANIA

Attained Age Rates -- Effective 5/1/2014 -- Area III (189-194)

PREFERRED MONTHLY BANK DRAFT RATES

FEMALE RATES						MALE RATES				
Plan A	**Plan B**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan B**	**Plan F**	**Plan G**	**Plan N**
128.41	135.80	158.25	136.17	108.44	**Under 65 OE**	147.68	156.17	181.98	156.60	124.71
305.79	346.51	439.06	397.34	327.75	**Under 65 UW**	351.66	398.49	504.92	456.94	376.91
128.41	135.80	158.25	136.17	108.44	**65**	147.68	156.17	181.98	156.60	124.71
128.41	135.80	158.25	136.17	108.44	**66**	147.68	156.17	181.98	156.60	124.71
134.19	141.97	165.14	142.80	113.53	**67**	154.32	163.26	189.91	164.22	130.56
139.91	148.11	171.73	149.13	118.46	**68**	160.89	170.33	197.49	171.50	136.23
145.52	154.22	178.46	155.60	123.39	**69**	167.35	177.35	205.23	178.94	141.90
150.95	159.82	184.73	161.62	128.04	**70**	173.59	183.79	212.43	185.86	147.24
155.46	165.04	190.77	167.43	132.71	**71**	178.78	189.80	219.39	192.54	152.61
159.97	170.27	196.82	173.24	137.37	**72**	183.97	195.81	226.34	199.23	157.98
164.49	175.49	202.87	179.05	142.04	**73**	189.16	201.82	233.30	205.91	163.34
169.00	180.72	208.92	184.87	146.70	**74**	194.35	207.83	240.25	212.59	168.71
173.68	186.13	215.18	190.87	151.52	**75**	199.74	214.05	247.46	219.50	174.25
177.73	191.21	221.65	196.93	156.59	**76**	204.39	219.89	254.90	226.47	180.08
181.83	196.37	228.23	203.09	161.76	**77**	209.11	225.82	262.47	233.56	186.02
186.19	201.81	235.16	209.57	167.17	**78**	214.12	232.08	270.43	241.00	192.24
190.62	207.35	242.21	216.16	172.68	**79**	219.21	238.45	278.54	248.58	198.58
195.12	212.98	249.38	222.87	178.30	**80**	224.39	244.93	286.79	256.30	205.04
200.18	219.34	258.21	231.07	185.35	**81**	230.21	252.24	296.94	265.73	213.16
205.34	225.81	267.21	239.43	192.56	**82**	236.14	259.69	307.29	275.34	221.44
210.79	232.64	276.67	248.20	200.10	**83**	242.41	267.54	318.17	285.43	230.12
216.36	239.61	286.32	257.17	207.81	**84**	248.81	275.55	329.27	295.74	238.99
222.03	246.72	296.18	266.32	215.69	**85**	255.33	283.73	340.61	306.27	248.05
228.09	254.01	306.59	275.89	223.89	**86**	262.30	292.11	352.57	317.28	257.48
234.29	261.48	317.27	285.73	232.32	**87**	269.44	300.70	364.86	328.59	267.16
240.65	269.14	328.23	295.83	240.97	**88**	276.75	309.50	377.47	340.20	277.12
246.92	276.71	339.16	305.89	249.62	**89**	283.95	318.22	390.03	351.78	287.06
253.08	284.19	350.01	315.91	258.24	**90**	291.04	326.81	402.52	363.30	296.97
259.07	291.47	361.15	326.15	267.13	**91**	297.93	335.19	415.32	375.07	307.20
265.17	298.89	372.52	336.60	276.20	**92**	304.95	343.72	428.39	387.09	317.63
270.86	305.85	383.36	346.58	284.91	**93**	311.48	351.73	440.86	398.57	327.64
276.63	312.93	394.39	356.74	293.77	**94**	318.13	359.87	453.55	410.25	337.83
282.50	320.12	405.63	367.08	302.79	**95**	324.88	368.14	466.47	422.15	348.21
288.15	326.53	413.74	374.43	308.85	**96**	331.38	375.50	475.80	430.59	355.17
293.92	333.06	422.01	381.91	315.02	**97**	338.00	383.01	485.32	439.20	362.28
299.80	339.72	430.45	389.55	321.32	**98**	344.76	390.67	495.02	447.98	369.52
305.79	346.51	439.06	397.34	327.75	**99**	351.66	398.49	504.92	456.94	376.91

During open enrollment and guaranteed issue periods preferred rates will apply.

Add one-time enrollment fee of $20.00 to the first premium.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

PENNSYLVANIA

Attained Age Rates -- Effective 5/1/2014 -- Area III (189-194)

STANDARD ANNUAL RATES

FEMALE RATES						MALE RATES				
Plan A	**Plan B**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan B**	**Plan F**	**Plan G**	**Plan N**
4,038.06	4,575.77	5,797.95	5,247.04	4,328.04	**Under 65 UW**	4,643.76	5,262.15	6,667.63	6,034.09	4,977.25
1,695.74	1,793.31	2,089.68	1,798.20	1,431.98	**65**	1,950.09	2,062.31	2,403.13	2,067.94	1,646.78
1,695.74	1,793.31	2,089.68	1,798.20	1,431.98	**66**	1,950.09	2,062.31	2,403.13	2,067.94	1,646.78
1,772.06	1,874.70	2,180.75	1,885.71	1,499.17	**67**	2,037.87	2,155.91	2,507.86	2,168.57	1,724.04
1,847.50	1,955.90	2,267.69	1,969.26	1,564.30	**68**	2,124.62	2,249.29	2,607.85	2,264.64	1,798.94
1,921.61	2,036.53	2,356.66	2,054.76	1,629.43	**69**	2,209.85	2,342.00	2,710.16	2,362.97	1,873.85
1,993.34	2,110.42	2,439.34	2,134.20	1,690.79	**70**	2,292.35	2,426.98	2,805.24	2,454.34	1,944.40
2,052.93	2,179.43	2,519.20	2,210.95	1,752.40	**71**	2,360.87	2,506.35	2,897.09	2,542.60	2,015.25
2,112.51	2,248.44	2,599.08	2,287.70	1,814.01	**72**	2,429.39	2,585.70	2,988.94	2,630.85	2,086.12
2,172.10	2,317.46	2,678.94	2,364.45	1,875.64	**73**	2,497.90	2,665.07	3,080.79	2,719.11	2,156.97
2,231.67	2,386.45	2,758.81	2,441.20	1,937.25	**74**	2,566.42	2,744.44	3,172.63	2,807.37	2,227.84
2,293.54	2,457.93	2,841.51	2,520.46	2,000.87	**75**	2,637.58	2,826.61	3,267.73	2,898.53	2,301.00
2,346.94	2,524.96	2,926.99	2,600.50	2,067.87	**76**	2,698.98	2,903.70	3,366.05	2,990.58	2,378.06
2,401.16	2,593.09	3,013.91	2,681.90	2,136.02	**77**	2,761.35	2,982.04	3,466.00	3,084.18	2,456.43
2,458.68	2,664.96	3,105.33	2,767.40	2,207.50	**78**	2,827.48	3,064.70	3,571.14	3,182.51	2,538.63
2,517.17	2,738.10	3,198.41	2,854.45	2,280.30	**79**	2,894.75	3,148.81	3,678.18	3,282.63	2,622.35
2,576.66	2,812.53	3,293.16	2,943.10	2,354.44	**80**	2,963.15	3,234.40	3,787.13	3,384.56	2,707.60
2,643.46	2,896.43	3,409.72	3,051.33	2,447.66	**81**	3,039.99	3,330.89	3,921.19	3,509.04	2,814.81
2,711.52	2,981.94	3,528.62	3,161.75	2,542.78	**82**	3,118.24	3,429.23	4,057.92	3,636.01	2,924.19
2,783.56	3,072.12	3,653.49	3,277.61	2,642.44	**83**	3,201.09	3,532.93	4,201.50	3,769.25	3,038.80
2,857.02	3,164.13	3,781.00	3,395.95	2,744.25	**84**	3,285.58	3,638.75	4,348.14	3,905.34	3,155.89
2,931.93	3,258.03	3,911.21	3,516.80	2,848.27	**85**	3,371.71	3,746.74	4,497.88	4,044.32	3,275.51
3,011.96	3,354.26	4,048.57	3,643.25	2,956.55	**86**	3,463.75	3,857.40	4,655.85	4,189.73	3,400.04
3,093.91	3,452.89	4,189.61	3,773.11	3,067.81	**87**	3,558.00	3,970.83	4,818.05	4,339.09	3,527.98
3,177.86	3,554.01	4,334.41	3,906.47	3,182.12	**88**	3,654.53	4,087.10	4,984.57	4,492.44	3,659.44
3,260.61	3,654.03	4,478.66	4,039.42	3,296.31	**89**	3,749.69	4,202.14	5,150.47	4,645.34	3,790.76
3,341.96	3,752.75	4,622.03	4,171.67	3,410.10	**90**	3,843.25	4,315.65	5,315.34	4,797.43	3,921.62
3,421.08	3,848.89	4,769.09	4,306.87	3,527.48	**91**	3,934.24	4,426.23	5,484.44	4,952.90	4,056.61
3,501.69	3,946.90	4,919.18	4,444.88	3,647.35	**92**	4,026.93	4,538.94	5,657.05	5,111.62	4,194.44
3,576.74	4,038.82	5,062.36	4,576.69	3,762.28	**93**	4,113.24	4,644.64	5,821.71	5,263.20	4,326.62
3,653.02	4,132.28	5,208.08	4,710.87	3,879.30	**94**	4,200.97	4,752.12	5,989.30	5,417.50	4,461.19
3,730.55	4,227.32	5,356.41	4,847.44	3,998.45	**95**	4,290.12	4,861.41	6,159.88	5,574.56	4,598.21
3,805.16	4,311.86	5,463.53	4,944.40	4,078.42	**96**	4,375.93	4,958.64	6,283.06	5,686.06	4,690.17
3,881.26	4,398.09	5,572.81	5,043.28	4,159.98	**97**	4,463.45	5,057.81	6,408.73	5,799.78	4,783.98
3,958.88	4,486.05	5,684.27	5,144.15	4,243.18	**98**	4,552.72	5,158.96	6,536.91	5,915.77	4,879.66
4,038.06	4,575.77	5,797.95	5,247.04	4,328.04	**99**	4,643.76	5,262.15	6,667.63	6,034.09	4,977.25

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted premium by 0.52, for quarterly premiums, multiply the above quoted premium by 0.265, and for monthly bank draft premiums, multiply the above-quoted premium by 0.0833.
During open enrollment and guaranteed issue periods preferred rates will apply.
Add one-time application fee of $20.00 to the first premium.

American Retirement Life Insurance Company

MEDICARE SUPPLEMENT

PENNSYLVANIA

Attained Age Rates -- Effective 5/1/2014 -- Area III (189-194)

STANDARD MONTHLY BANK DRAFT RATES

FEMALE RATES						MALE RATES				
Plan A	**Plan B**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan B**	**Plan F**	**Plan G**	**Plan N**
336.37	381.16	482.97	437.08	360.53	**Under 65 UW**	386.83	438.34	555.41	502.64	414.60
141.26	149.38	174.07	149.79	119.28	**65**	162.44	171.79	200.18	172.26	137.18
141.26	149.38	174.07	149.79	119.28	**66**	162.44	171.79	200.18	172.26	137.18
147.61	156.16	181.66	157.08	124.88	**67**	169.75	179.59	208.90	180.64	143.61
153.90	162.93	188.90	164.04	130.31	**68**	176.98	187.37	217.23	188.64	149.85
160.07	169.64	196.31	171.16	135.73	**69**	184.08	195.09	225.76	196.84	156.09
166.05	175.80	203.20	177.78	140.84	**70**	190.95	202.17	233.68	204.45	161.97
171.01	181.55	209.85	184.17	145.97	**71**	196.66	208.78	241.33	211.80	167.87
175.97	187.30	216.50	190.57	151.11	**72**	202.37	215.39	248.98	219.15	173.77
180.94	193.04	223.16	196.96	156.24	**73**	208.08	222.00	256.63	226.50	179.68
185.90	198.79	229.81	203.35	161.37	**74**	213.78	228.61	264.28	233.85	185.58
191.05	204.75	236.70	209.95	166.67	**75**	219.71	235.46	272.20	241.45	191.67
195.50	210.33	243.82	216.62	172.25	**76**	224.83	241.88	280.39	249.12	198.09
200.02	216.00	251.06	223.40	177.93	**77**	230.02	248.40	288.72	256.91	204.62
204.81	221.99	258.67	230.52	183.88	**78**	235.53	255.29	297.48	265.10	211.47
209.68	228.08	266.43	237.78	189.95	**79**	241.13	262.30	306.39	273.44	218.44
214.64	234.28	274.32	245.16	196.12	**80**	246.83	269.43	315.47	281.93	225.54
220.20	241.27	284.03	254.18	203.89	**81**	253.23	277.46	326.64	292.30	234.47
225.87	248.40	293.93	263.37	211.81	**82**	259.75	285.65	338.02	302.88	243.59
231.87	255.91	304.34	273.02	220.12	**83**	266.65	294.29	349.98	313.98	253.13
237.99	263.57	314.96	282.88	228.60	**84**	273.69	303.11	362.20	325.31	262.89
244.23	271.39	325.80	292.95	237.26	**85**	280.86	312.10	374.67	336.89	272.85
250.90	279.41	337.25	303.48	246.28	**86**	288.53	321.32	387.83	349.00	283.22
257.72	287.63	348.99	314.30	255.55	**87**	296.38	330.77	401.34	361.45	293.88
264.72	296.05	361.06	325.41	265.07	**88**	304.42	340.46	415.21	374.22	304.83
271.61	304.38	373.07	336.48	274.58	**89**	312.35	350.04	429.03	386.96	315.77
278.39	312.60	385.02	347.50	284.06	**90**	320.14	359.49	442.77	399.63	326.67
284.98	320.61	397.27	358.76	293.84	**91**	327.72	368.70	456.85	412.58	337.92
291.69	328.78	409.77	370.26	303.82	**92**	335.44	378.09	471.23	425.80	349.40
297.94	336.43	421.69	381.24	313.40	**93**	342.63	386.90	484.95	438.42	360.41
304.30	344.22	433.83	392.42	323.15	**94**	349.94	395.85	498.91	451.28	371.62
310.75	352.14	446.19	403.79	333.07	**95**	357.37	404.96	513.12	464.36	383.03
316.97	359.18	455.11	411.87	339.73	**96**	364.51	413.05	523.38	473.65	390.69
323.31	366.36	464.22	420.11	346.53	**97**	371.81	421.32	533.85	483.12	398.51
329.77	373.69	473.50	428.51	353.46	**98**	379.24	429.74	544.52	492.78	406.48
336.37	381.16	482.97	437.08	360.53	**99**	386.83	438.34	555.41	502.64	414.60

During open enrollment and guaranteed issue periods preferred rates will apply.

Add one-time enrollment fee of $20.00 to the first premium.

Locate appropriate Area according to the applicant's ZIP Code in the ZIP Code chart below.

PENNSYLVANIA ZIP CODES:

Area	**3-Digit ZIP Codes**
Area I	155, 157-188, 195-196
Area II	150-154, 156
Area III	189-194

If You choose to pay Your premium on a mode other than annual, the following modal factors will be applied to the annual premiums:

Semi-annual	Annual premium * 0.52
Quarterly	Annual premium * 0.265
Monthly Bank Draft	Annual premium * 0.0833

PREMIUM INFORMATION

Your premium will increase each year because of the increase in your attained age. We, American Retirement Life Insurance Company, can also raise your premium if (a) we change the rates which apply to all policies of this form issued by us and in-force in your state; (b) coverage under Medicare changes; or (c) you move to a different ZIP Code location. We will send you a written notice at least thirty (30) days in advance when we change the premium rates for all policies of this form issued by us and in-force in your state.

There will be a one-time application fee of $20 added to the first premium. This application fee is refundable if the policy is not issued.

DISCLOSURES

Use this Outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an Outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and American Retirement Life Insurance Company.

30-DAY RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to American Retirement Life Insurance Company, P. O. Box 26580, Austin, TX 78755-0580. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of your premiums including the $20 application fee.

POLICY REPLACEMENT

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

NOTICE

This policy may not fully cover all of your medical costs. Neither American Retirement Life Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. We may cancel your policy 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.

RENEWABILITY

This policy is guaranteed renewable for life.

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 $1,216	$0	$1,216 (Part A Deductible)
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $608 a day	$608 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 day	All but $152 a day	$0	Up to $152 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 co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** 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 policy'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 $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your 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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN B
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 B PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,216	$1,216 (Part A Deductible)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $608 a day	$608 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 day	All but $152 a day	$0	Up to $152 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 co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** 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 policy'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 B
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN B 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 $147 of Medicare-approved amounts*	$0	$0	$147(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 $147 of Medicare-approved amounts*	$0	$0	$147(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 B PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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 $1,216	$1,216 (Part A Deductible)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $608 a day	$608 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 day	All but $152 a day	Up to $152 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 co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** 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 policy'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 $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your 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 $147 of Medicare-approved amounts*	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$147 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONTINUED)

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 G
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 G PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,216	$1,216 (Part A Deductible)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $608 a day	$608 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 day	All but $152 a day	Up to $152 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 co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** 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 policy'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 G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G 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 $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 G PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONTINUED)

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN G 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 $1,216	$1,216 (Part A Deductible)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $608 a day	$608 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 day	All but $152 a day	Up to $152 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 co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** 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 policy'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 $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your 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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 co-payment 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 co-payment 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 $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES –			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONTINUED)

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 $147 of Medicare-approved amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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	$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

New Business Submission Form/FaxApp

To: Cigna Supplemental Benefits **Fax #: 877-704-8186**

AGENT INFORMATION *(Required)*

FROM:	
PHONE #:	FAX #:
WRITING #:	EMAIL:
DATE:	NUMBER OF PAGES: + cover

APPLICANT INFORMATION *(Required)*

NAME:	SS#:	☐ Combo ☐ CWA ☐ Draft
NAME:	SS#:	☐ Combo ☐ CWA ☐ Draft
NAME:	SS#:	☐ Combo ☐ CWA ☐ Draft
NAME:	SS#:	☐ Combo ☐ CWA ☐ Draft
NAME:	SS#:	☐ Combo ☐ CWA ☐ Draft

All applications submitted with a single cover sheet must be from the same writing agent.

PROCEDURES

For the fastest service, send one application per cover sheet and only one application per transmission, unless sending a combo application. Check the Combo box if you are submitting multiple applications for one applicant. You may send up to five applications with a single cover sheet per transmission. **However, do not exceed 25 pages per transmission.**

Simply complete the application, and fax the following to **877-704-8186**.

- FaxApp Cover Sheet
- Application in numeric page order
- Any state-specific or replacement forms, if applicable
- **Copy of the initial premium check, if collected from the customer at the point of sale**

Medicare supplement under age 65 (disabled) cases are not eligible for the FaxApp Program. You must mail the completed application with a check for the first month's premium to the Imaging – New Business address below.

PREMIUM

- Agents are encouraged to utilize the Bank Draft Authorization form to draft for the first premium in lieu of collecting the initial premium from the applicant.
- If you collected initial premium from the applicant, **please indicate the case number on the check** and mail the check, stapled to the top of the FaxApp cover sheet, to:

Imaging – New Business
P.O. Box 559015, Austin, TX 78755-9015

We must receive the premium within 10 days of receipt of the application. If it is not received within 10 days, we will send you a letter stating that the money for the policy must be submitted immediately. If we do not receive the check after 20 days, a letter will be sent stating that the contract will be cancelled in 5 days, unless we receive payment for the issued contract. **If we do not receive payment after 25 days, a letter will be sent to you and the applicant stating that the file has been closed and the policy has been cancelled due to non-payment of premium.**

American Retirement Life Insurance Company Whole Life Insurance

Cash Value Calculation Worksheet - Pennsylvania

(Use this information to complete the required Disclosure Form (AR-LIFE-DISC-PA) Guaranteed Cash Value section of the application packet)

Age	Sex	Tobacco	5 Years	10 Years	20 Years
64	M	No	91.3147736	248.7597841	538.4532007
65	M	No	97.4683507	259.2793788	550.2785585
66	M	No	104.0308620	270.1300835	561.4353390
67	M	No	110.7039875	281.1761334	571.6714898
68	M	No	117.2405379	292.1743359	580.7818063
69	M	No	123.6628420	302.8220573	588.5932396
70	M	No	130.0428533	312.9766641	594.9866337
71	M	No	136.5080797	322.5379584	600.1893159
72	M	No	143.1949679	331.6012634	604.6078771
73	M	No	150.0570244	340.3898812	608.2637524
74	M	No	156.7074243	348.7574321	610.9632841
75	M	No	162.8958520	356.4311371	612.4352648
76	M	No	168.3653927	363.0665820	612.8344894
77	M	No	173.0876522	368.3734752	612.5809014
78	M	No	177.3721931	372.2023546	611.5718667
79	M	No	181.4025858	374.4908734	609.5842951
80	M	No	185.0679556	375.1097731	606.0401608
81	M	No	188.1657916	374.4308919	601.1968981
82	M	No	190.3324240	372.9556515	596.2274929
83	M	No	191.0491008	370.4759666	591.0290059
84	M	No	190.0296010	366.7813819	585.5742600
85	M	No	187.1915639	361.6555385	579.9772458

Age	Sex	Tobacco	5 Years	10 Years	20 Years
64	M	Yes	92.4578771	249.1108854	531.0710014
65	M	Yes	98.0653739	258.8482904	541.6128770
66	M	Yes	104.3124276	268.9837102	551.4402647
67	M	Yes	110.7101681	279.3166235	560.2230990
68	M	Yes	116.8917980	289.4914492	567.7040912
69	M	Yes	122.9691258	299.1098189	573.6702271
70	M	Yes	128.9603598	308.0090840	577.9744005
71	M	Yes	134.8799614	316.0980843	580.9171809
72	M	Yes	140.9725473	323.6118479	583.0822922
73	M	Yes	147.1723826	330.9639501	584.5920192
74	M	Yes	152.8877559	338.0317695	585.2856002
75	M	Yes	157.8909419	344.4117527	584.7828813
76	M	Yes	162.0399502	349.5721969	583.0662559
77	M	Yes	165.3684187	353.1646070	580.6499892
78	M	Yes	168.4389689	355.0624229	577.4669052
79	M	Yes	171.6725508	355.2348550	573.3157687
80	M	Yes	174.7820125	353.5361158	567.6005177
81	M	Yes	177.2239363	350.4510252	560.6311127
82	M	Yes	178.5051849	346.6284576	553.7758527
83	M	Yes	177.8909711	341.8404589	547.1138817
84	M	Yes	174.9023236	335.9239258	541.1269169
85	M	Yes	169.6112692	328.6485113	536.0557224

Age	Sex	Tobacco	5 Years	10 Years	20 Years
64	F	No	75.4242677	209.3408842	479.9341649
65	F	No	78.5512364	217.0271626	491.8949099
66	F	No	81.7291309	224.8644923	503.7743026
67	F	No	84.8898443	232.8560318	515.2538711
68	F	No	88.0416722	241.0067989	525.6766480
69	F	No	93.5316238	251.2890779	536.1996213
70	F	No	99.2974972	262.0178061	545.9963073
71	F	No	105.2273727	272.7482068	556.6980247
72	F	No	111.3937473	283.0730271	569.1623767
73	F	No	117.7965389	293.0461064	581.9563113
74	F	No	124.4773693	302.7718594	593.7535149
75	F	No	131.4988878	312.1199488	603.1134228
76	F	No	138.4549804	321.4099548	609.1558286
77	F	No	144.7926583	330.2027809	611.5127074
78	F	No	150.5688197	337.5661965	613.1959184
79	F	No	155.8621068	343.3668631	617.8579139
80	F	No	160.4468388	347.8922416	623.3058597
81	F	No	165.0982462	353.8687725	628.5772084
82	F	No	169.8094514	362.9924693	633.8918337
83	F	No	173.3528884	373.1892362	639.0319957
84	F	No	175.4532871	382.3811044	643.7196772
85	F	No	176.6641400	388.4111465	647.6232284

Age	Sex	Tobacco	5 Years	10 Years	20 Years
64	F	Yes	79.4562518	220.1343140	479.4741820
65	F	Yes	84.1384264	227.7193620	487.6815892
66	F	Yes	88.7935828	235.3405715	495.6967747
67	F	Yes	93.3291136	243.0030923	503.1616406
68	F	Yes	97.7406679	250.7568724	509.1721654
69	F	Yes	101.9898524	258.6407128	513.7511944
70	F	Yes	106.1777239	266.7307938	517.4164076
71	F	Yes	110.4770787	274.5307927	522.7063733
72	F	Yes	114.9856754	281.3761869	531.0384063
73	F	Yes	119.7678018	287.3242220	540.7999919
74	F	Yes	124.9087256	292.4969300	550.7922799
75	F	Yes	130.4027888	296.8132455	558.7448011
76	F	Yes	135.4946104	300.9156771	562.6666545
77	F	Yes	139.2893643	304.2921898	562.1226520
78	F	Yes	141.7760835	305.5958935	560.7557129
79	F	Yes	142.9999634	304.7585121	563.3194300
80	F	Yes	142.8468834	302.3863492	567.1749087
81	F	Yes	142.8284992	302.6151362	571.2728678
82	F	Yes	143.2076609	308.2621529	576.1133659
83	F	Yes	142.3353058	317.0077845	581.7445532
84	F	Yes	140.0747425	326.9849935	588.4138873
85	F	Yes	137.2947780	334.8416935	595.5460526

How to calculate the CV amounts needed: Simply find the proper calculation figure above based on the issue age of the applicant, gender and tobacco use. Multiply the corresponding number shown above by the number of Whole Life units (per $1,000 amount) being purchased.

For Example: A 65 year old, non-tobacco, Female is purchasing $10,000 (10 units) of coverage:

Number of years Policy has been in force		Cash Value per $1,000 (of total Face Amount)
5	78.5512364 (x 10)	**$ 785.51**
10	217.0271626 (x 10)	**$ 2,170.27**
20	491.8949099 (x 10)	**$ 4,918.95**
Age 65	(When purchasing at age 64 or older, this amount is always **$0**)	