

**Anthem Blue Cross and Blue Shield  
Medicare Supplement Application — Missouri**


New Enrollment     Change to Enrollment

**Send no money now!** For assistance, please contact us at 800-652-6387 or contact your Anthem Blue Cross and Blue Shield Insurance Agent. To be considered for coverage, you must live within our 85-county service area in Eastern, Central and Southern Missouri.

**Section A: Applicant Information (Please print and use black ink only.)**

Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Home Street Address	City	County	State    Zip Code
Social Security Number ____   ____   ____	Date of Birth ____   ____   ____	Age	Home Phone Number (    )
E-mail Address (optional)	Preferred Language Spoken: _____ Written: _____		

**Section B: Medicare Information (From your red, white and blue Medicare card.)**

Medicare Claim Number: _____	 <b>1-800-MEDICARE (1-800-633-4227)</b>
Hospital (Part A) Effective Date: _____ MONTH/YEAR	NAME OF BENEFICIARY <b>JANE DOE</b>
Medical (Part B) Effective Date: _____ MONTH/YEAR	MEDICARE CLAIM NUMBER <b>000-00-0000-A</b>
	SEX <b>FEMALE</b>
	IS ENTITLED TO <b>HOSPITAL (PART A) MEDICAL (PART B)</b>
	EFFECTIVE DATE <b>07-01-2010 07-01-2010</b>

Is a member of your household enrolled with us in a Medicare Supplement Plan?    Yes    No   If "Yes," you may be eligible for a discount\* on your premium. Please provide the following information for that household member:

Name \_\_\_\_\_ Medicare Claim Number \_\_\_\_\_  
Anthem Blue Cross and Blue Shield Medicare Supplement Identification Number \_\_\_\_\_

\*See the Outline of Coverage - Premium Information page for details.

In Missouri (excluding 30 counties in the Kansas City area): Anthem Blue Cross and Blue Shield is the trade name for RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.



## Section F: Conditions of Application (Answer all questions.)

**Anthem Blue Cross and Blue Shield may request additional information, which may delay processing of this application. If the health care provider bills for this information, I understand that I may be responsible for the fee.**

*Please read the six statements below.*

### Important Statements

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested during your entitlement to benefits under Medicaid, for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

### General Information

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.)**

To the best of your knowledge:

1. a. Did you turn age 65 in the last 6 months?  Yes  No  
b. Did you enroll in Medicare Part B in the last 6 months?  Yes  No  
c. If yes, what is the effective date? \_\_\_\_\_

**(continued)**

## Section F: Conditions of Application (continued)

2. Are you covered for medical assistance through the state Medicaid program?  Yes  No  
[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?  Yes  No
- b. Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium?  Yes  No
3. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, like a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" 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?  Yes  No
- c. Was this your first time in this type of Medicare plan?  Yes  No
- d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?  Yes  No
4. a. Do you have another Medicare Supplement policy in force?  Yes  No
- b. If so, with what company, and what plan do you have?  
\_\_\_\_\_
- c. If so, do you intend to replace your current Medicare Supplement policy with this policy?  Yes  No
5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)  Yes  No
- 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 "END" blank.  
START \_\_\_\_/\_\_\_\_/\_\_\_\_ END \_\_\_\_/\_\_\_\_/\_\_\_\_

## Section G: Health History and Medical Provider Information (If this section applies to you, answer all questions.)

**READ CAREFULLY – This section may not be applicable to you.** Please '✓' the box if any of the following apply to you:

- Your coverage will start **3 months before or after your 65th birthday**;
- Your coverage will start when you are age **65 or older and within 6 months of your Medicare Part B coverage effective date**;
- You are **under age 65** and eligible for Medicare due to a disability and applying when 1st eligible; **OR**
- You qualify for guaranteed-issue coverage for another reason

If you checked any of the above, please **skip** this Section.

1. Are you currently confined, or has confinement been recommended to a bed, hospital, nursing facility or other care facility, or do you need the assistance of a wheelchair for any daily activity?  Yes  No
2. Within the past two years, have you been hospitalized two or more times or been confined to a nursing home for a total of two weeks or longer?  Yes  No
3. Within in the past two years, have you been advised to have surgery that has not yet been done?  Yes  No

**Section G: Health History and Medical Provider Information**  
**(If this section applies to you, answer all questions.) (continued)**

4. Within the past five years, have you been told you had, been consulted for treatment of, sought treatment for, had treatment recommended for, received treatment for, been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for any of the following conditions:
- a. Heart conditions, including but not limited to, heart attack, open heart surgery, placement of pacemaker, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, coronary artery disease, peripheral vascular disease, heart rhythm disorders, transient ischemic attack (TIA) or stroke?  Yes  No
  - b. Alzheimer's disease, Parkinson's disease, senile dementia, organic brain disorder or other senility disorder?  Yes  No
  - c. Any respiratory condition, including but not limited to, Chronic Obstructive Pulmonary Disease (COPD) or emphysema (excluding allergies and asthma)?  Yes  No
  - d. Internal cancer, leukemia, Hodgkin's disease, insulin dependent diabetes, chronic kidney disease (including end-stage renal disease), kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, any organ transplant (except cornea), amputation or joint replacement due to disease?  Yes  No
5. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?  Yes  No

If you are not taking any medications, please check here:  I am not taking any medications.

*If you answered "YES" to any of the questions above, or if you are taking any medications, give complete details (see the example below as a guideline). If additional space is needed, attach separate sheet.*

Item #	Specific illness, injury, procedure, surgery, hospitalization or condition	Name of Medication and Dates of Use		Name, Address, Telephone (w/area code), and Fax for Doctor	Dates of illness, injury, procedure, surgery, hospitalization or condition	
					Begin	End/Current

**Note: This row is an example of how to complete this section. Please begin with next row.**

4a	Congestive Heart Failure	Lanoxin		Dr. John Doe 10 High Street, Suite 45 Anywhere, US 19222 1-555-555-1000 (phone) 1-800-555-2000 (fax)	11/1999	7/2005
		1/2001	7/2005			

Name of Primary Care Physician: \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

## Section H: Authorizations and Agreements

I, the applicant or my authorized representative, have read and understand this Application in its entirety.

I, the applicant or my authorized representative, have personally completed this Application. I understand and agree to the Replacement Notification provided with this Application and to the Conditions of Application and the Authorization and Agreements in this Application. If my Application is accepted, it will become part of the agreement between the company and myself.

I, the applicant or my authorized representative, acknowledge receipt of:

- “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare,” and
- the “Outline of Coverage.”

I, the applicant or my authorized representative, understand that the selling agent (if applicable) has no authority to promise coverage or to modify the Company’s underwriting policy or terms of any company coverage.

I, the applicant, am currently enrolled in an Anthem Blue Cross and Blue Shield individual health policy and wish to cancel that policy when this Medicare Supplement Application is approved and I become enrolled.

Policy Number: \_\_\_\_\_

If your present Anthem Blue Cross and Blue Shield coverage provides benefits for a spouse and/or dependents who are not eligible for Medicare, complete the following. This will enable us to offer them continuous coverage that is comparable to your current coverage.

Name:	Relationship:
DOB: ___ / ___ / _____	SSN: ___   ___   _____
Name:	Relationship:
DOB: ___ / ___ / _____	SSN: ___   ___   _____
Name:	Relationship:
DOB: ___ / ___ / _____	SSN: ___   ___   _____

I, the applicant or my authorized representative, acknowledge responsibility for any overdraft fees permitted by state law.

I, the applicant or my authorized representative, understand that there is a 6-month benefit waiting period for coverage of any condition for which I received medical treatment or advice within the 6 months prior to the effective date of this Medicare Supplement policy. I understand that the time I was covered under any other health insurance will be counted toward this 6-month benefit waiting period, if there is not a break in coverage greater than 63 days between the termination of the other coverage and the effective date of this Medicare Supplement policy.

**I, the applicant or my authorized representative, understand that if I incur an illness or change in medical condition during the time between the date I sign this application and the effective date of coverage, I must notify Anthem Blue Cross and Blue Shield in writing of any such illness or change, and such notice shall be a condition of my coverage. (This does not apply if I am applying during my open enrollment period or qualify for guaranteed-issue coverage for another reason.)**

I, the applicant or my authorized representative, understand that Anthem Blue Cross and Blue Shield may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction. The debit transaction will appear on my bank statement, although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem Blue Cross and Blue Shield automatic debit process and will only occur each time I send a check to Anthem Blue Cross and Blue Shield. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.

(continued)

**Section H: Authorizations and Agreements (continued)**

I, the applicant or my authorized representative, alone have responsibility for accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, even information about my Medicare coverage, is false, incomplete or omitted. I understand that the company may void all coverage from the original effective date of the policy only in the event that I failed to accurately respond to questions regarding my past or present health conditions.

**Conditioned Authorization to Use or Obtain Medical Information to Pay Claims**

**Protected Health Information (PHI) to be Used and/or Disclosed:** Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-related complex), but not including psychotherapy notes.

**Entities or Persons Authorized to Use or Disclose:** U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist or any other medical or medically related facility or professional.

**Entities or Persons Authorized to Receive:** The company, its agents, employees, designees, or representatives, including my company agent or broker, for the purpose(s) described below.

**Purpose of this Authorization:** By signing this form, you will authorize us to use and/or disclose your PHI to determine if you will be enrolled in our health plan or are eligible for benefits, or for underwriting or risk rating your enrollment or eligibility. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits.

**Effect of Declining:** If I decide not to sign this authorization, you may decline to enroll me in our health plan. This PHI may be used or disclosed subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

**Expiration:** This authorization will expire upon termination of any company coverage that may be in effect.

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

**Anthem Blue Cross and Blue Shield, PO Box 37730, Louisville, KY 40233-7730**

I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my PHI, as described in this authorization.

If the authorization is signed by a personal representative, on behalf of the individual, complete the following:

	X	
<i>Print Applicant's Name</i>	<i>Applicant's Signature</i>	<i>Date</i>

Name of the other person or persons authorized to receive my PHI:

<i>Name of Authorized Person</i>	<i>Relationship to Applicant</i>

X	
<i>Applicant's Signature</i>	<i>Date</i>

**A photocopy of this authorization is as valid as the original, and I and my Anthem Blue Cross and Blue Shield agent or broker are entitled to receive a copy of this form after I sign it.**

*(continued)*

## Section I: Policy or Certificate Issuance

**Important: This Application will not be processed unless the applicant signs below. By signing below, you agree to the acknowledgments in Section H. Please do not cancel your present coverage, if any, until you receive documentation from Anthem Blue Cross and Blue Shield, such as an ID card or written notification, showing that your Application has been approved.**

To ensure timely processing, verify the following:

- 1) Complete, sign and date all sections as indicated by signature boxes.
- 2) If you want the convenience of automatic bank draft or credit card for payment purposes, be sure to complete the **Premium Payment Form**.

Please mail the entire Application (including the Premium Payment Form) to the address below –

Are you working with an insurance agent?  
(No additional charges when working with your agent.)

If yes, mail to:

Anthem Blue Cross and Blue Shield  
PO Box 37810  
Louisville, KY 40233-7810 OR  
Fax to: 800-848-2512

Did you contact Anthem Blue Cross and  
Blue Shield directly?

If yes, mail to:

Enrollment Processing Center  
PO Box 5007  
Middletown, NY 10940-9007 OR  
Fax to: 888-884-5736

Signature of Applicant, or Authorized Representative (if applicable)\*

Date

X

X

\*If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to application (such as a Power of Attorney).

**SEND NO MONEY NOW – PAYMENT IS NOT DUE UNTIL YOUR APPLICATION IS APPROVED  
AND YOU RECEIVE YOUR PREMIUM NOTICE.**

**Section J: Agent/Broker Information Only:** If application is being made through an agent/broker, he or she must complete the following, and the Notice of Replacement included with the application, if appropriate. (Attach additional sheets if necessary.)

**Important:** Before this form can be processed, the agent/broker's current health and life license must be on file. In addition, the agent/broker must be appointed with us.

Agency No.: \_\_\_\_\_ Agent/Broker No.: \_\_\_\_\_  
(Any commission will be processed using these identification numbers.)

Agent/Broker's Printed Name: John Conner Phone No. ( \_\_\_\_\_ ) 800-700-1246

Fax No. ( \_\_\_\_\_ ) 800-995-9913 E-mail address: john@johnconner.com

Street Address 10425 Saddle Creek Drive

Sacramento

CA

95829

City

State

ZIP Code

**Attestation - Please check one of the following:**

- I did not assist this applicant in completing and/or submitting this application by phone, e-mail or in person.
- I assisted the applicant in completing and/or submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

**Notice:** If you state as an agent any material fact that you know to be false, you are subject to a civil penalty.

(continued)

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**Section J: Agent/Broker Information Only (continued):** If application is being made through an agent/broker, he or she must complete the following, and the Notice of Replacement included with the application, if appropriate. *(Attach additional sheets if necessary.)*

Please list all health insurance policies you have issued to the applicant that are still in force and any other health insurance issued in the past 5 years that are no longer in force and submit with the application, as required:

_____	_____
Name of Policy	Name of Insurance Company
Policy Date from: <u>   </u> / <u>   </u>	_____
MM  YYYY	Street Address of Insurance Company
Policy Date from: <u>   </u> / <u>   </u>	_____
MM  YYYY	City/State of Insurance Company

I have read and understand the application. I additionally certify that I have given the applicant the "Guide to Health Insurance for People with Medicare" and an outline of coverage for the policy applied for, and that the applicant has both Parts A and B of Medicare. The policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

Agent/Broker's Signature: X \_\_\_\_\_ Date of Signature: X \_\_\_\_\_

Agent/Broker: Submit completed application to:

Anthem Blue Cross and Blue Shield  
PO Box 37810  
Louisville, KY 40233-7810  
or Fax to 800-848-2512

# Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Anthem Blue Cross and Blue Shield  
PO Box 37810, Louisville, KY 40233-7810

## Save This Notice! It May Be Important to You in the Future.

According to information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

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

### Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage, because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
  - No change in benefits, but lower premiums.
  - Fewer benefits and lower premiums.
  - My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
  - Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
- \_\_\_\_\_
- Other. (please specify) \_\_\_\_\_

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting 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 preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

\_\_\_\_\_  
(Signature of Agent, Broker or Other Representative)\*  
Typed Name and Address of Issuer, Agent or Broker

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Date)

\*Signature not required for direct response sales.

# Premium Payment Form

(Please Print Clearly)



## Save \$2 on Your Monthly Premium — Enroll in Automatic Bank Draft

If you sign up for monthly Automatic Bank Draft (sometimes referred to as Electronic Funds Transfer or EFT), we will pass the savings on to you. By eliminating a monthly bill, you save as well in time and postage. In addition, there's no need to worry about your premium if you are traveling or hospitalized.

Applicant's Full Name: \_\_\_\_\_ Date of Application: \_\_\_\_\_

**Please Return this Form With Your Application.**

### Section 1. Amount of Premium

I understand that the initial premium for the coverage I have selected is \$\_\_\_\_\_.  
*(If your application is accepted and the amount you indicated is less than or more than the actual premium amount, the difference will be reflected as a debit or a credit on the first bill you receive from Anthem Blue Cross and Blue Shield (the Company) — provided that the amount is within our payment guidelines. If the amount is not within our guidelines, we will notify you.)*

### Section 2: Payment Method:

I am paying the initial premium by (check only one option):

- Credit Card     Debit Card  
 Automatic bank account withdrawal

#### A. If Paying by Credit or Debit Card:

A credit/debit card can be used for the initial premium payment. If your application is accepted, you will be billed for future payments (unless you chose Annual Billing\* on your Application) or you can sign up for monthly automatic bank withdrawal.

**Note:** If you select Annual as your billing preference on your Application, we will charge your account for premium from your effective date through the end of the year.

**Authorization:** I authorize the Company to charge the credit/debit card indicated below for the amount specified in Section 1.

Applicant's Signature: \_\_\_\_\_

X \_\_\_\_\_

#### Following is my credit/debit card information

Cardholder's Name (as shown on the credit/debit card): \_\_\_\_\_

**If Applicant is using the credit/debit card of another cardholder:** By signing this form, Applicant represents and warrants that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for this payment and any charges accruing to it.

Type of Credit/Debit Card:  VISA     MasterCard

Credit Card Number: \_\_\_\_\_

Expiration Date (month/year): \_\_\_\_/\_\_\_\_

Cardholder Billing Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### B. If Paying by Monthly Automatic Bank Withdrawal:

Deduct premiums from the below account for (check one):

- My first month payment only  
 My first and ongoing payments  
 My ongoing payments only (I am making my first payment by another method)

*If you want to change your payment method later, please contact us.*

**Authorization and Signature(s):** I/we authorize the Company to make withdrawals in the amount of the then-current premium rate, based on the billing frequency indicated on my Application, from the:

- Checking Account:**     Personal     Business  
 **Savings Account:**     Personal     Business

*named below and I/we authorize the financial institution to charge such withdrawals to my/our account.*

#### Provide the following bank account information\*\*

Name(s) on Checking/Savings Account: \_\_\_\_\_

\_\_\_\_\_

Name of Bank (or other Financial Institution): \_\_\_\_\_

Financial Institution Routing No.:

(first 9 digits in lower left corner of check/deposit slip)

\_\_\_\_\_

Account No.: \_\_\_\_\_

\*\* You may attach a check or savings account deposit slip from your bank, marked "VOID" in ink.

### C. Authorization:

This authorization remains in effect until the Company and the financial institution above receive notification from me or one of us (if a joint account) of its termination in such time and manner as to provide reasonable time to act on it, or the policy terminates.

Each person listed on the checking/savings account must sign here:

X \_\_\_\_\_

X \_\_\_\_\_