

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., P. O. Box 105146, Atlanta, GA 30348-5146

**APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE
STANDARD UNDERWRITING**

AGENT/BROKER NAME	AGENT NO.
JULIA B. DAVIS	600302

PLEASE PRINT

Mail Policy to: Insured Agent

Proposed Insured	Social Security No.	Sex	State Of Birth	Age	Born			Height & Weight			
					Mo.	Day	Yr.	Ft.	In.	Lbs.	
Residence Address (Street or Route & Box No.)	City	County	State	Zip Code			Telephone No.				
							-		()		

Are you a legal citizen of the United States or its possessions? If "No," coverage is not available Yes No

To whom should premium notices be sent? Proposed Insured, or: Payor's Name _____

Relationship to Proposed Insured _____ Phone number () _____

Complete Address _____ Zip Code | | | | - | | | |

Plan to be issued: Plan A Plan B Plan C Plan D* Plan F
 High Deductible Plan F* Optional Two-Year Rate Guaranty Rider*

*May not be available in all states - refer to rate sheet

Open Enrollment: Requested Effective Date _____

(a) Are you eligible for coverage under the "Open Enrollment" period (the six month period beginning with the first month in which you are both age 65 or older and enroll in Medicare Part B)? Yes No

(b) Are you eligible for coverage under the 63-day "guaranty" period (the first 63 days beginning on the termination date of other supplemental insurance coverage). If "Yes," please submit proof of involuntary termination of coverage. Yes No

Premium Computation:
Modal Premium: \$ _____
+ One-time Fee For Two-Year Rate
Guaranty Rider (Not available in all states) . \$ _____
= Total Initial Premium Paid \$ _____

Premium Mode: Annual Semi-Annual
 Quarterly Monthly Direct Monthly Bank Draft*

*Requested Draft Date _____

SECTION A: INSURANCE INFORMATION

1. A. Medicare claim number _____
B. Are you covered under Medicare Part A? Yes No If "Yes," Effective Date _____
C. Are you covered under Medicare Part B? Yes No If "Yes," Effective Date _____
D. Are you covered under Social Security Disability? Yes No If "Yes," Effective Date _____

TO THE BEST OF YOUR KNOWLEDGE: *If "Yes," to question 2b or 3c, complete Replacement Form.

2. Do you have another Medicare supplement policy, certificate or coverage in force? Yes No
A. If "Yes," with which company? _____ Policy No _____
B. If "Yes," do you intend to replace your current Medicare supplement policy with this policy, certificate or coverage?* Yes No
C. Paid-to-date of current policy _____ Expiration Date of current policy _____
3. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy? Yes No
A. If "Yes," with which company? _____ Policy No _____
B. What kind of policy? _____
C. If "Yes," do you intend to replace any of this other coverage with this policy?* Yes No
4. Are you covered for medical assistance through the state Medicaid program:
A. as a Specified Low-Income Medicare Beneficiary (SLMB)? Yes No
B. as a Qualified Medicare Beneficiary (QMB)? Yes No
C. for other Medicaid medical benefits? Yes No

5. **NOTICE:** A. You do not need more than one Medicare supplement policy. B. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. C. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. D. 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 policy will be reinstated if requested within 90 days of losing Medicaid eligibility. E. 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).

(Application continued on back)

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NOTICE TO THE APPLICANT – PART ONE

Printed in Compliance with Public Law 91-508

Thank you for considering Bankers Fidelity Life Insurance Company for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of the investigation.

NOTICE TO APPLICANT – PART TWO – MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Bankers Fidelity Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Bankers Fidelity Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

SECTION B: MEDICAL QUESTIONS

IF YOU ANSWER "YES" TO ANY PART OF QUESTIONS 6-13, COVERAGE IS **NOT** AVAILABLE. IF YOU QUALIFY FOR OPEN ENROLLMENT, YOU DO NOT HAVE TO ANSWER QUESTIONS 6-13.

- 6. Have you been diagnosed with or treated for, by a member of the medical profession, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or have you tested positive on any AIDS-related blood test? Yes No
- 7. Do you have Alzheimer's disease, cirrhosis of the liver, emphysema, chronic obstructive pulmonary disease (COPD) or any other chronic lung disease or disorder? Yes No
- 8. A. Within the past 2 years have you had or been treated for internal cancer, leukemia, malignant melanoma, hepatitis, heart attack, stroke or organ transplant surgery? Yes No
 B. Are you taking any medication as a consequence of, or related to, cancer or its treatment? Yes No
- 9. Are you currently on dialysis or have you been treated for kidney failure? Yes No
- 10. Has surgery for cataracts, a heart condition or joint replacement been recommended which has not been completed? Yes No
- 11. Are you bedridden or confined to a wheelchair, or during the past 2 years have you had any type of amputation caused by disease? Yes No
- 12. Are you now in, or have you been advised to enter within the next 12 months, any hospital convalescent, nursing or retirement home? Yes No
- 13. Have you been hospitalized more than 3 times within the last 2 years? Yes No

14. I hereby apply to Bankers Fidelity Life Insurance Company for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are true. I agree the policy shall not be effective unless it has actually been issued, received by me and the first premium paid, all during my lifetime and before any change in my health as stated herein. I have received an outline of coverage for the policy applied for and a "Guide To Health Insurance For People With Medicare." To determine my eligibility for the coverage applied for herein, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to Bankers Fidelity Life Insurance Company or its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original. This authorization is valid for 30 months from the date of this application. I acknowledge that I or my authorized representative are entitled to a copy of this authorization upon request.

The undersigned Proposed Insured and agent state that the Proposed Insured has read or had read to him/her the completed application and that the Proposed Insured realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

CAUTION: If your answers on this application are incorrect or untrue, Bankers Fidelity Life Insurance Company may have the right to deny benefits or rescind your policy.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and could subject such person to civil fines and/or criminal penalties.

Dated at _____, on _____ X _____
 (City and State) (Month, Day, Year) Proposed Insured's signature. Please read item 14 before signing.

X _____ 600302
 Agent's signature **Julia B. Davis** Agent's number

WRITING AGENT'S STATEMENT:

I have sold the following policies to the Proposed Insured which are still in force: _____

I have sold the following policies to the Proposed Insured within the past 5 years which are no longer in force: _____

I, the undersigned agent, certify that: (1) I have personally interviewed the Proposed Insured; (2) I have accurately recorded the information supplied by the Proposed Insured; and (3) I have given the Proposed Insured an outline of coverage for the policy applied for and a "Guide To Health Insurance For People With Medicare." I certify that to the best of my knowledge and belief the coverage applied for herein does not duplicate coverage the Proposed Insured currently has in force.

Dated at _____, on _____ X _____
 (City and State) (Month, Day, Year) Agent's signature Agent's number