

Underwritten by

PacifiCare[®]
Life Assurance Company

SecureHorizons[®]
from **PacifiCare**[®]

Texas Application for SecureHorizons[®] Medicare Supplement Plan

Eligibility:

To be eligible for this Medicare supplement plan you must be:

- Enrolled under Federal Medicare Hospital Insurance (Part A) and Federal Medicare Medical Insurance (Part B) at the time you apply.
- A resident of Texas.
- Age 65 or older; or
- Under age 65, enrolled in Medicare Parts A and B by reason of disability (eligible for Plan A only) — see Guaranteed Issue Guide for specific limitations.

Instructions:

- Read IMPORTANT NOTICE below before completing this application.
- Provide ALL requested information.
- Type or print clearly in ink.
- Sign and date in all places indicated.
- Submit application within thirty (30) days of the applicant's signature date.
- Submit one month's premium with application in the form of a check made payable to PacifiCare Life Assurance Company, or a completed EasyPay form to have premiums drafted from your checking or credit card account.

IMPORTANT NOTICE: Refer to the Guaranteed Issue Guide to determine eligibility for automatic acceptance. If eligible, indicate which situation is applicable in the Guaranteed Issue section. You are not required to complete the Statement of Health section.



Section I — Applicant Information

Social Security Number -- Date of Birth --
MONTH DAY YEAR Gender: M F

First Name _____ Middle Initial _____ Last Name _____

Residential Address _____ County _____

City _____ State _____ Zip _____

Telephone (____) _____ E-mail Address _____

Billing Address (If different from above) _____

City _____ State _____ Zip _____

Section II — Plan Information

Select Plan: Plan A Plan C
 Plan F Plan High Deductible F Plan G Plan J

Requested Effective Date: --
MONTH DAY YEAR (may not be 29th, 30th or 31st of the month)

Select Payment Mode:

Automatic Payment Options— Automatic Checking Account Debit Credit Card Authorization

Direct Bill Options— Annual Semi-Annual Quarterly Monthly

Draft Initial Premium (automatic modes only)? Yes No **or** First Premium Enclosed \$ _____

Mail Policy to: Agent Policyholder

Section III — Medicare Information from your red, white and blue Medicare card

Medicare Number ---

Hospital (Part A) Effective Date _____ Medical (Part B) Effective Date _____

Note: You must be enrolled in Medicare Parts A and B to be eligible for coverage. Please provide a copy of your Medicare card or application if newly enrolled.

Section IV — Current Health Coverage 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. Please mark "Yes" or "No" (below) with an "X" to the best of your knowledge:

- Yes No Did you turn age 65 in the last 6 months?
- Yes No Did you enroll in Medicare Part B in the last 6 months?
 If yes, what is the effective date? _____
- Yes No 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.)
 Yes No If yes, will Medicaid pay your premiums for this Medicare supplement policy?
 Yes No If yes, do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium?

Section IV — Current Health Coverage Information (continued)

4. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave “END” blank. START ___ / ___ / ___ END ___ / ___ / ___
- Yes No 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 Was this your first time in this type of Medicare plan?
- Yes No Did you drop a Medicare supplement policy to enroll in the Medicare plan?
5. Yes No Do you have another Medicare supplement policy in force?
- If yes, with what company, and what plan do you have? _____
- Yes No ▪ If yes, do you intend to replace your current Medicare supplement policy with this policy?
6. Yes No Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)?
- If yes, with what company and what kind of policy? _____
- 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 V — Guaranteed Issue

See the Guaranteed Issue Guide to determine if you qualify for Guaranteed Issue coverage.

If you qualify for Guaranteed Issue, under what situation do you qualify? _____
(Give Situation Number)

Please include a copy of the required documentation with this application.

Section VI — Statement of Health

If you are applying for coverage during open enrollment or during a Guaranteed Issue period, do not complete this section.

If the answer to any of the health questions 3-12 is “Yes,” you are not eligible for coverage.

Height _____ ft. _____ in. Weight _____ lbs.

- Yes No Have you used tobacco products within the last 1 year(s)?
- Yes No Were you eligible for Medicare before age 65? If yes, explain disability _____

- Yes No Are you currently confined, or has confinement been recommended, to a nursing facility, hospital or other care facility, or do you need the assistance of a wheelchair?
- Yes No Within the last 2 year(s), have you been advised to have a transplant, or a cardiac/heart operation or treatment, or any other surgery that has not yet been completed?
- Yes No Within the last 2 year(s), have you been hospitalized 2 or more times?
- Yes No Within the last 2 year(s), have you had or been advised to have kidney dialysis?
- Yes No Within the last 2 year(s), have you been diagnosed or treated for Alzheimer’s disease, dementia, senility, Parkinson’s disease, multiple sclerosis, muscular dystrophy or amyotrophic lateral sclerosis (ALS)?
- Yes No Within the last 2 year(s), have you been diagnosed or treated for internal cancer, malignant melanoma, leukemia, Hodgkin’s disease, systemic lupus, cirrhosis of the liver, alcohol or drug abuse, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

Section VI — Statement of Health (continued)

9. Yes No Within the last 2 year(s), have you been diagnosed or treated for a heart attack, stroke, transient ischemic attack (TIA), heart valve surgery, congestive heart failure, peripheral vascular disease or enlarged heart?
10. Yes No Within the last 2 year(s), have you been diagnosed or treated for disabling arthritis or degenerative bone disease?
11. Yes No Within the last 2 year(s), have you been diagnosed or treated for emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?
12. Yes No Are you an insulin-dependent diabetic?
13. Yes No Do you have any disease or disorder not mentioned above? If yes, please explain _____
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Section VII — Conditions of Eligibility and Authorization

Before you apply, it is important that you read the following eligibility information and statements, then sign and date in the required place.

1. You do not need more than one (1) Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefit.
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 area to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the Medicaid program, including your benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).
7. This application will become part of the policy for which you are applying.
8. You will receive no coverage under this plan unless PacifiCare Life Assurance Company approves this application. PacifiCare Life Assurance Company is not liable for bills incurred before the effective date of coverage. Cashing of your check or automatic bank draft does not constitute approval of your application.

Section VII — Conditions of Eligibility and Authorization (continued)

- 9. Only PacifiCare Life Assurance Company can approve this application. A sales representative cannot grant approval, change terms or waive requirements.
- 10. Authorization for Disclosures of Personal Information: I authorize any “provider of care,” insurer or health plan to disclose to PacifiCare Life Assurance Company, or its representatives, all “medical information” (as those terms are defined in Texas) regarding me, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for evaluating this application, determining eligibility for benefits and/or for quality assurance and peer review. This authorization is effective immediately and shall remain for a period of twenty-four (24) months, except that it shall remain effective for use with any claim for benefits for as long as PacifiCare Life Assurance Company coverage is in effect. A photocopy of this authorization is as valid as the original. My authorized representative and I are entitled to receive a copy of this authorization.
- 11. You may revoke this authorization at any time before you become a PacifiCare Life Assurance Company insured, except for instances that we have already taken action based on the authorization. Your revocation must be mailed to PacifiCare Life Assurance Company, P.O. Box 13547, Pensacola, FL 32591-3547.

I have read the Outline of Coverage and Conditions. I understand and agree to them. I alone am responsible for the accuracy and completeness of this application for health coverage.

I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

I understand the eligibility information and have answered the questions in this application to the best of my knowledge. I certify that I meet the eligibility requirements outlined. I acknowledge that I have also received a copy of the “Guide to Health Insurance for People with Medicare” and an Outline of Coverage. I can expect to receive a copy of my completed application when my policy is issued to me if accepted for coverage.

Applicant’s Full Signature _____ Date _____

Applicant’s Full Name (Please print) _____

Authorized Representative _____ *Please check box and attach Durable Power of Attorney*

Section VIII — Medicare Supplement (Agent Completes)

List policies sold to this Applicant that are still in force _____

List policies sold to this Applicant in the past five (5) years that are no longer in force _____

I certify that the policy information listed above represents all health policies that I (or my agency) have sold to the applicant. *(If none, so state)*

Agent’s Signature _____ Date _____

Agent’s Full Name *(Please print)* DONALD KENTON HENRY Agent Number 170672

FMO Name _____ FMO Number _____

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