

**HEARTLAND NATIONAL
LIFE INSURANCE COMPANY**

Medicare Supplement Administrative Office:
PO Box 10812, Clearwater, FL 33757-8812



**APPLICATION FOR
MEDICARE SUPPLEMENT INSURANCE**

INDIANA



HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Outline of Medicare Supplement Coverage

Benefit Plans A, D, F, G, M, and N

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Plans E, H, I, and J are no longer available for sale.

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 copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- 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*	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
		Skilled Nursing Facility Coinsurance	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	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 Deductible					
			Part B Excess (100%)	Part B Excess (100%)	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	Foreign Travel Emergency
						Out-of-pocket limit \$4640 paid at 100% after limit reached				
						Out-of-pocket limit \$2320 paid at 100% after limit 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 \$2000 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2000. 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.

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
INDIANA Standard Plans MALE Rates - ANNUAL

For use in zip codes: All zips except 460-464

Attained Age	Non-Tobacco User						Tobacco User					
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	947	1,191	1,369	1,211	1,114	953	1,053	1,323	1,521	1,345	1,239	1,058
66	992	1,251	1,429	1,272	1,171	998	1,102	1,390	1,588	1,414	1,301	1,109
67	1,037	1,312	1,489	1,333	1,227	1,044	1,152	1,457	1,655	1,482	1,363	1,161
68	1,076	1,368	1,545	1,390	1,280	1,089	1,196	1,520	1,717	1,546	1,422	1,209
69	1,115	1,425	1,601	1,448	1,332	1,133	1,241	1,583	1,779	1,609	1,481	1,258
70	1,155	1,481	1,657	1,505	1,383	1,177	1,286	1,645	1,842	1,674	1,540	1,306
71	1,194	1,538	1,713	1,563	1,436	1,222	1,331	1,709	1,904	1,737	1,598	1,355
72	1,236	1,594	1,771	1,619	1,489	1,265	1,373	1,770	1,967	1,799	1,654	1,406
73	1,263	1,641	1,818	1,668	1,533	1,305	1,404	1,824	2,021	1,853	1,702	1,450
74	1,291	1,690	1,866	1,717	1,577	1,345	1,435	1,877	2,075	1,907	1,750	1,494
75	1,319	1,737	1,913	1,766	1,620	1,385	1,466	1,930	2,129	1,962	1,798	1,539
76	1,346	1,785	1,961	1,815	1,664	1,426	1,496	1,983	2,183	2,016	1,846	1,583
77	1,375	1,833	2,011	1,863	1,706	1,464	1,528	2,037	2,234	2,070	1,896	1,626
78	1,390	1,871	2,050	1,902	1,740	1,498	1,546	2,080	2,278	2,113	1,935	1,664
79	1,406	1,909	2,089	1,942	1,774	1,533	1,563	2,123	2,321	2,156	1,973	1,702
80	1,420	1,948	2,128	1,981	1,809	1,568	1,580	2,165	2,364	2,201	2,011	1,740
81	1,435	1,986	2,167	2,020	1,843	1,603	1,597	2,208	2,408	2,244	2,049	1,778
82	1,452	2,026	2,204	2,057	1,878	1,636	1,614	2,252	2,449	2,286	2,087	1,817
83	1,462	2,060	2,238	2,092	1,908	1,667	1,624	2,290	2,487	2,324	2,120	1,853
84	1,471	2,095	2,271	2,126	1,940	1,699	1,635	2,330	2,525	2,363	2,154	1,889
85	1,481	2,129	2,305	2,160	1,970	1,731	1,645	2,368	2,563	2,401	2,188	1,925
86	1,490	2,163	2,339	2,193	2,001	1,762	1,656	2,406	2,601	2,439	2,223	1,961
87	1,501	2,198	2,373	2,230	2,031	1,795	1,668	2,441	2,637	2,478	2,257	1,995
88	1,508	2,208	2,384	2,241	2,041	1,805	1,677	2,453	2,650	2,491	2,268	2,004
89	1,515	2,219	2,396	2,252	2,052	1,814	1,685	2,467	2,663	2,504	2,280	2,014
90	1,523	2,229	2,408	2,264	2,063	1,824	1,694	2,479	2,677	2,516	2,292	2,024
91	1,531	2,240	2,419	2,276	2,074	1,833	1,702	2,492	2,691	2,529	2,303	2,035
92	1,539	2,251	2,431	2,287	2,085	1,843	1,711	2,505	2,704	2,542	2,315	2,045
93	1,546	2,263	2,444	2,299	2,095	1,852	1,719	2,518	2,718	2,554	2,326	2,056
94	1,553	2,275	2,456	2,311	2,106	1,862	1,728	2,530	2,732	2,567	2,339	2,067
95	1,561	2,286	2,469	2,322	2,116	1,871	1,736	2,543	2,746	2,580	2,351	2,077
96	1,568	2,298	2,482	2,335	2,127	1,881	1,745	2,556	2,759	2,592	2,362	2,088
97	1,576	2,309	2,494	2,346	2,137	1,890	1,753	2,568	2,773	2,606	2,374	2,098
98	1,583	2,321	2,507	2,358	2,148	1,900	1,761	2,581	2,787	2,619	2,386	2,109
99	1,590	2,334	2,520	2,370	2,158	1,909	1,770	2,594	2,801	2,632	2,397	2,119

Quarterly: 0.25000 Monthly: .08333

Modal Factors: Semi Annual: 0.5000

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
INDIANA Standard Plans MALE Rates - ANNUAL

For use in zip codes: 463-464

Attained Age	Non-Tobacco User						Tobacco User					
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,184	1,489	1,711	1,514	1,393	1,191	1,316	1,654	1,901	1,682	1,548	1,323
66	1,239	1,564	1,786	1,591	1,464	1,248	1,378	1,737	1,985	1,767	1,626	1,387
67	1,296	1,639	1,861	1,666	1,534	1,305	1,440	1,822	2,068	1,852	1,704	1,451
68	1,345	1,709	1,931	1,737	1,600	1,361	1,496	1,899	2,146	1,932	1,778	1,511
69	1,394	1,781	2,001	1,810	1,665	1,416	1,551	1,979	2,224	2,012	1,851	1,572
70	1,444	1,851	2,071	1,881	1,729	1,472	1,608	2,057	2,302	2,092	1,925	1,633
71	1,493	1,922	2,141	1,954	1,795	1,527	1,663	2,136	2,380	2,171	1,997	1,694
72	1,544	1,992	2,214	2,024	1,861	1,581	1,716	2,212	2,459	2,249	2,067	1,757
73	1,579	2,051	2,273	2,086	1,917	1,632	1,756	2,280	2,526	2,317	2,128	1,812
74	1,614	2,112	2,332	2,146	1,971	1,682	1,794	2,346	2,594	2,384	2,187	1,868
75	1,649	2,171	2,392	2,207	2,025	1,732	1,832	2,413	2,661	2,453	2,248	1,923
76	1,683	2,231	2,451	2,269	2,080	1,782	1,870	2,479	2,728	2,520	2,307	1,979
77	1,719	2,292	2,513	2,328	2,133	1,830	1,910	2,546	2,793	2,587	2,369	2,033
78	1,737	2,339	2,562	2,377	2,175	1,873	1,932	2,600	2,847	2,641	2,418	2,080
79	1,757	2,387	2,611	2,427	2,218	1,917	1,954	2,653	2,901	2,695	2,466	2,128
80	1,775	2,435	2,660	2,476	2,261	1,960	1,975	2,706	2,955	2,751	2,513	2,175
81	1,794	2,483	2,709	2,525	2,303	2,004	1,996	2,760	3,010	2,805	2,561	2,223
82	1,815	2,533	2,755	2,571	2,347	2,045	2,017	2,816	3,061	2,858	2,608	2,272
83	1,827	2,575	2,797	2,615	2,385	2,084	2,030	2,863	3,109	2,905	2,651	2,317
84	1,839	2,619	2,839	2,657	2,425	2,124	2,043	2,912	3,156	2,954	2,693	2,361
85	1,851	2,661	2,882	2,699	2,463	2,163	2,057	2,959	3,204	3,002	2,735	2,406
86	1,863	2,703	2,924	2,742	2,501	2,203	2,070	3,007	3,251	3,049	2,779	2,451
87	1,876	2,747	2,966	2,788	2,538	2,244	2,086	3,052	3,296	3,098	2,821	2,493
88	1,885	2,760	2,981	2,801	2,552	2,256	2,096	3,066	3,312	3,114	2,835	2,505
89	1,894	2,773	2,995	2,816	2,565	2,268	2,107	3,084	3,329	3,130	2,850	2,517
90	1,903	2,787	3,010	2,830	2,579	2,280	2,117	3,099	3,346	3,146	2,864	2,530
91	1,914	2,800	3,024	2,845	2,592	2,292	2,128	3,115	3,363	3,161	2,879	2,544
92	1,923	2,814	3,039	2,859	2,606	2,303	2,138	3,131	3,381	3,177	2,893	2,557
93	1,932	2,829	3,054	2,874	2,619	2,315	2,149	3,147	3,398	3,193	2,908	2,570
94	1,942	2,843	3,070	2,888	2,632	2,327	2,160	3,163	3,415	3,209	2,924	2,583
95	1,951	2,858	3,086	2,903	2,645	2,339	2,170	3,179	3,432	3,225	2,938	2,596
96	1,960	2,872	3,102	2,919	2,658	2,351	2,181	3,194	3,449	3,241	2,953	2,610
97	1,969	2,887	3,118	2,933	2,672	2,363	2,191	3,210	3,466	3,258	2,967	2,623
98	1,979	2,901	3,134	2,948	2,685	2,375	2,202	3,226	3,483	3,274	2,982	2,636
99	1,988	2,917	3,150	2,962	2,698	2,387	2,212	3,242	3,501	3,289	2,996	2,649

Modal Factors: Semi Annual: 0.5000

Quarterly: 0.25000

Monthly: .08333

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
INDIANA Standard Plans MALE Rates - ANNUAL

For use in zip codes: 460-462

Attained Age	Non-Tobacco User					
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	N/A	N/A	N/A	N/A	N/A	N/A
65	1,023	1,286	1,477	1,308	1,203	1,028
66	1,070	1,351	1,542	1,374	1,264	1,078
67	1,119	1,416	1,607	1,439	1,325	1,127
68	1,162	1,476	1,668	1,500	1,382	1,175
69	1,204	1,538	1,728	1,563	1,438	1,223
70	1,247	1,598	1,789	1,625	1,493	1,271
71	1,289	1,660	1,849	1,687	1,550	1,319
72	1,334	1,720	1,912	1,748	1,607	1,366
73	1,363	1,772	1,963	1,801	1,655	1,409
74	1,394	1,824	2,014	1,854	1,702	1,452
75	1,424	1,875	2,066	1,906	1,749	1,496
76	1,454	1,927	2,117	1,960	1,797	1,539
77	1,484	1,979	2,171	2,011	1,842	1,580
78	1,500	2,020	2,213	2,053	1,879	1,618
79	1,517	2,061	2,255	2,096	1,915	1,655
80	1,533	2,103	2,297	2,139	1,953	1,693
81	1,549	2,144	2,339	2,181	1,989	1,731
82	1,568	2,188	2,379	2,221	2,027	1,766
83	1,578	2,224	2,416	2,258	2,060	1,800
84	1,588	2,262	2,452	2,295	2,094	1,834
85	1,598	2,298	2,489	2,331	2,127	1,868
86	1,609	2,335	2,525	2,368	2,160	1,903
87	1,620	2,372	2,562	2,408	2,192	1,938
88	1,628	2,384	2,574	2,419	2,204	1,948
89	1,636	2,395	2,587	2,432	2,215	1,959
90	1,644	2,407	2,599	2,444	2,228	1,969
91	1,653	2,418	2,612	2,457	2,239	1,979
92	1,661	2,430	2,624	2,469	2,250	1,989
93	1,669	2,443	2,638	2,482	2,262	2,000
94	1,677	2,456	2,652	2,494	2,273	2,010
95	1,685	2,468	2,665	2,507	2,285	2,020
96	1,693	2,481	2,679	2,521	2,296	2,030
97	1,701	2,493	2,693	2,533	2,307	2,041
98	1,709	2,506	2,706	2,546	2,319	2,051
99	1,717	2,519	2,720	2,558	2,330	2,061

Modal Factors:

Semi Annual: 0.5000

Quarterly: 0.25000

Monthly: .08333

Attained Age	Tobacco User					
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	N/A	N/A	N/A	N/A	N/A	N/A
65	1,137	1,428	1,642	1,452	1,337	1,142
66	1,190	1,500	1,714	1,526	1,404	1,198
67	1,244	1,573	1,786	1,599	1,472	1,253
68	1,292	1,640	1,854	1,669	1,536	1,305
69	1,340	1,709	1,921	1,737	1,598	1,358
70	1,389	1,776	1,988	1,807	1,662	1,410
71	1,436	1,845	2,055	1,875	1,725	1,463
72	1,482	1,911	2,124	1,943	1,785	1,517
73	1,516	1,969	2,182	2,001	1,838	1,565
74	1,549	2,026	2,240	2,059	1,889	1,613
75	1,582	2,084	2,298	2,118	1,941	1,661
76	1,615	2,141	2,356	2,176	1,993	1,709
77	1,650	2,199	2,412	2,234	2,046	1,756
78	1,669	2,246	2,459	2,281	2,088	1,797
79	1,687	2,291	2,506	2,328	2,130	1,838
80	1,705	2,337	2,552	2,376	2,171	1,879
81	1,724	2,384	2,599	2,423	2,212	1,920
82	1,742	2,432	2,644	2,468	2,253	1,962
83	1,753	2,473	2,685	2,509	2,289	2,001
84	1,765	2,515	2,726	2,551	2,326	2,039
85	1,776	2,556	2,767	2,592	2,362	2,078
86	1,788	2,597	2,808	2,633	2,400	2,117
87	1,801	2,636	2,847	2,676	2,436	2,153
88	1,810	2,648	2,860	2,689	2,449	2,164
89	1,819	2,663	2,875	2,703	2,461	2,174
90	1,829	2,677	2,890	2,717	2,474	2,185
91	1,838	2,690	2,905	2,730	2,486	2,197
92	1,847	2,704	2,920	2,744	2,499	2,208
93	1,856	2,718	2,934	2,758	2,511	2,220
94	1,865	2,731	2,949	2,771	2,525	2,231
95	1,874	2,745	2,964	2,785	2,538	2,242
96	1,883	2,759	2,979	2,799	2,550	2,254
97	1,892	2,772	2,994	2,814	2,563	2,265
98	1,902	2,786	3,008	2,827	2,575	2,277
99	1,911	2,800	3,023	2,841	2,588	2,288

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
INDIANA Standard Plans FEMALE Rates - ANNUAL

For use in zip codes: All zips except 460-464

Attained Age	Non-Tobacco User						Plan N
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N	
0-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	824	1,037	1,191	1,054	969	829	829
66	863	1,089	1,243	1,107	1,019	869	869
67	902	1,142	1,296	1,161	1,068	909	909
68	937	1,190	1,344	1,210	1,113	947	947
69	972	1,239	1,393	1,260	1,159	985	985
70	1,007	1,288	1,441	1,310	1,205	1,023	1,023
71	1,042	1,337	1,490	1,360	1,250	1,061	1,061
72	1,075	1,385	1,541	1,409	1,296	1,100	1,100
73	1,099	1,428	1,583	1,451	1,334	1,135	1,135
74	1,124	1,469	1,625	1,493	1,372	1,170	1,170
75	1,149	1,510	1,667	1,536	1,411	1,205	1,205
76	1,173	1,552	1,710	1,579	1,449	1,240	1,240
77	1,196	1,595	1,750	1,620	1,485	1,274	1,274
78	1,210	1,628	1,784	1,654	1,514	1,303	1,303
79	1,224	1,662	1,817	1,689	1,545	1,333	1,333
80	1,238	1,697	1,851	1,722	1,574	1,362	1,362
81	1,251	1,731	1,885	1,756	1,604	1,392	1,392
82	1,263	1,762	1,918	1,790	1,634	1,423	1,423
83	1,272	1,792	1,947	1,821	1,660	1,451	1,451
84	1,281	1,823	1,977	1,850	1,687	1,478	1,478
85	1,289	1,852	2,006	1,880	1,714	1,506	1,506
86	1,298	1,882	2,036	1,909	1,740	1,533	1,533
87	1,306	1,911	2,064	1,941	1,767	1,562	1,562
88	1,313	1,921	2,075	1,950	1,775	1,569	1,569
89	1,319	1,931	2,086	1,960	1,784	1,577	1,577
90	1,325	1,941	2,096	1,969	1,792	1,584	1,584
91	1,332	1,950	2,107	1,979	1,802	1,592	1,592
92	1,338	1,960	2,117	1,988	1,810	1,601	1,601
93	1,344	1,969	2,128	1,998	1,819	1,609	1,609
94	1,351	1,979	2,138	2,007	1,829	1,618	1,618
95	1,357	1,988	2,149	2,017	1,838	1,626	1,626
96	1,363	1,998	2,160	2,026	1,848	1,635	1,635
97	1,370	2,007	2,170	2,037	1,858	1,643	1,643
98	1,376	2,017	2,181	2,048	1,867	1,652	1,652
99	1,382	2,026	2,191	2,058	1,877	1,660	1,660

Modal Factors:

Semi Annual: 0.5000

Quarterly: 0.25000

Monthly: .08333

Attained Age	Tobacco User						Plan N
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N	
0-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	916	1,152	1,323	1,171	1,077	921	921
66	959	1,210	1,381	1,230	1,132	965	965
67	1,002	1,268	1,439	1,289	1,187	1,010	1,010
68	1,040	1,322	1,494	1,344	1,237	1,052	1,052
69	1,078	1,376	1,549	1,400	1,287	1,094	1,094
70	1,116	1,431	1,604	1,455	1,337	1,136	1,136
71	1,155	1,485	1,659	1,510	1,387	1,178	1,178
72	1,194	1,541	1,712	1,565	1,439	1,223	1,223
73	1,221	1,587	1,758	1,611	1,482	1,261	1,261
74	1,247	1,634	1,805	1,658	1,524	1,299	1,299
75	1,275	1,681	1,851	1,705	1,567	1,337	1,337
76	1,301	1,728	1,898	1,752	1,609	1,375	1,375
77	1,330	1,772	1,944	1,800	1,649	1,415	1,415
78	1,344	1,810	1,981	1,838	1,683	1,449	1,449
79	1,359	1,847	2,018	1,877	1,716	1,483	1,483
80	1,374	1,884	2,055	1,915	1,749	1,516	1,516
81	1,389	1,921	2,092	1,954	1,781	1,550	1,550
82	1,404	1,960	2,130	1,990	1,816	1,582	1,582
83	1,414	1,993	2,163	2,022	1,846	1,613	1,613
84	1,423	2,025	2,195	2,055	1,875	1,643	1,643
85	1,433	2,058	2,228	2,089	1,905	1,674	1,674
86	1,442	2,092	2,261	2,122	1,936	1,704	1,704
87	1,451	2,124	2,295	2,155	1,963	1,736	1,736
88	1,458	2,134	2,306	2,166	1,973	1,745	1,745
89	1,466	2,145	2,318	2,176	1,982	1,753	1,753
90	1,473	2,155	2,330	2,187	1,992	1,761	1,761
91	1,481	2,166	2,341	2,199	2,001	1,770	1,770
92	1,488	2,176	2,353	2,209	2,011	1,778	1,778
93	1,495	2,187	2,364	2,220	2,020	1,787	1,787
94	1,503	2,199	2,376	2,230	2,030	1,795	1,795
95	1,510	2,209	2,388	2,241	2,040	1,805	1,805
96	1,517	2,220	2,399	2,252	2,051	1,814	1,814
97	1,525	2,230	2,411	2,264	2,061	1,824	1,824
98	1,533	2,241	2,422	2,276	2,073	1,833	1,833
99	1,541	2,252	2,434	2,287	2,083	1,843	1,843

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
INDIANA Standard Plans FEMALE Rates - ANNUAL

For use in zip codes: 463-464

Attained Age	Non-Tobacco User						Tobacco User					
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,030	1,296	1,489	1,317	1,212	1,036	1,144	1,440	1,654	1,464	1,346	1,151
66	1,078	1,361	1,554	1,383	1,274	1,086	1,199	1,513	1,727	1,538	1,415	1,206
67	1,127	1,427	1,620	1,451	1,335	1,137	1,253	1,585	1,799	1,612	1,484	1,262
68	1,171	1,488	1,680	1,513	1,391	1,184	1,300	1,653	1,868	1,680	1,546	1,315
69	1,214	1,548	1,741	1,575	1,449	1,232	1,348	1,720	1,936	1,750	1,609	1,368
70	1,259	1,610	1,802	1,638	1,506	1,279	1,395	1,789	2,005	1,819	1,671	1,420
71	1,303	1,671	1,863	1,700	1,563	1,327	1,444	1,856	2,074	1,888	1,733	1,473
72	1,344	1,732	1,926	1,761	1,620	1,375	1,493	1,926	2,140	1,956	1,799	1,529
73	1,374	1,785	1,979	1,814	1,667	1,419	1,526	1,984	2,198	2,014	1,852	1,576
74	1,404	1,836	2,031	1,866	1,715	1,463	1,559	2,042	2,256	2,072	1,905	1,624
75	1,436	1,888	2,084	1,921	1,764	1,506	1,593	2,101	2,314	2,132	1,959	1,671
76	1,467	1,940	2,137	1,973	1,811	1,550	1,626	2,160	2,372	2,190	2,012	1,719
77	1,496	1,993	2,187	2,025	1,856	1,592	1,662	2,215	2,430	2,251	2,062	1,769
78	1,513	2,035	2,229	2,067	1,893	1,629	1,680	2,262	2,476	2,298	2,104	1,811
79	1,530	2,078	2,272	2,111	1,931	1,666	1,699	2,309	2,523	2,346	2,145	1,853
80	1,547	2,121	2,314	2,153	1,968	1,703	1,717	2,355	2,569	2,393	2,186	1,896
81	1,564	2,163	2,356	2,195	2,005	1,740	1,736	2,401	2,615	2,442	2,227	1,938
82	1,579	2,203	2,397	2,237	2,042	1,779	1,756	2,450	2,662	2,487	2,270	1,977
83	1,591	2,240	2,434	2,276	2,075	1,814	1,767	2,491	2,703	2,528	2,307	2,016
84	1,601	2,278	2,471	2,313	2,109	1,848	1,779	2,532	2,744	2,569	2,344	2,054
85	1,612	2,315	2,508	2,350	2,142	1,882	1,791	2,573	2,785	2,611	2,381	2,092
86	1,622	2,352	2,545	2,387	2,175	1,917	1,803	2,615	2,826	2,652	2,420	2,130
87	1,633	2,389	2,581	2,426	2,208	1,952	1,814	2,655	2,868	2,694	2,454	2,170
88	1,641	2,401	2,594	2,438	2,219	1,962	1,823	2,668	2,883	2,707	2,466	2,181
89	1,649	2,414	2,607	2,450	2,229	1,971	1,832	2,681	2,897	2,721	2,478	2,191
90	1,657	2,426	2,620	2,462	2,240	1,980	1,841	2,694	2,912	2,734	2,490	2,202
91	1,665	2,438	2,633	2,474	2,252	1,991	1,851	2,707	2,926	2,748	2,501	2,212
92	1,672	2,450	2,647	2,486	2,262	2,001	1,860	2,721	2,941	2,761	2,513	2,223
93	1,680	2,462	2,660	2,497	2,274	2,012	1,869	2,734	2,955	2,775	2,525	2,233
94	1,688	2,474	2,673	2,509	2,286	2,022	1,878	2,748	2,970	2,788	2,537	2,244
95	1,696	2,486	2,686	2,521	2,298	2,033	1,888	2,761	2,985	2,801	2,550	2,256
96	1,704	2,497	2,699	2,533	2,310	2,043	1,897	2,775	2,999	2,816	2,563	2,268
97	1,712	2,509	2,713	2,546	2,322	2,054	1,906	2,788	3,014	2,830	2,577	2,280
98	1,720	2,521	2,726	2,559	2,334	2,064	1,917	2,801	3,028	2,845	2,591	2,292
99	1,728	2,533	2,739	2,573	2,346	2,075	1,926	2,816	3,043	2,859	2,604	2,303

Modal Factors: Semi Annual: 0.5000

Quarterly: 0.25000

Monthly: .08333

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
INDIANA Standard Plans FEMALE Rates - ANNUAL

For use in zip codes: 460-462

Attained Age	Non-Tobacco User						Tobacco User					
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	889	1,119	1,286	1,138	1,047	895	988	1,244	1,428	1,264	1,163	994
66	931	1,175	1,342	1,195	1,100	938	1,035	1,306	1,491	1,328	1,222	1,042
67	974	1,232	1,399	1,253	1,153	982	1,082	1,369	1,554	1,392	1,281	1,090
68	1,011	1,285	1,451	1,306	1,202	1,023	1,123	1,427	1,613	1,451	1,335	1,135
69	1,049	1,337	1,504	1,360	1,252	1,064	1,164	1,485	1,672	1,512	1,390	1,181
70	1,088	1,391	1,556	1,415	1,301	1,105	1,205	1,545	1,732	1,571	1,443	1,227
71	1,125	1,443	1,609	1,468	1,350	1,146	1,247	1,603	1,791	1,630	1,497	1,272
72	1,161	1,496	1,663	1,521	1,399	1,188	1,289	1,663	1,848	1,689	1,554	1,320
73	1,187	1,541	1,709	1,566	1,440	1,226	1,318	1,713	1,898	1,740	1,599	1,361
74	1,213	1,586	1,754	1,612	1,481	1,263	1,346	1,764	1,948	1,790	1,645	1,402
75	1,240	1,630	1,800	1,659	1,523	1,301	1,376	1,815	1,998	1,841	1,692	1,443
76	1,267	1,676	1,846	1,704	1,564	1,338	1,404	1,865	2,049	1,891	1,737	1,484
77	1,292	1,721	1,889	1,749	1,603	1,375	1,435	1,913	2,099	1,944	1,781	1,528
78	1,306	1,758	1,925	1,785	1,635	1,407	1,451	1,954	2,139	1,985	1,817	1,564
79	1,321	1,794	1,962	1,823	1,668	1,439	1,467	1,994	2,179	2,026	1,853	1,601
80	1,336	1,832	1,998	1,859	1,700	1,471	1,483	2,034	2,218	2,067	1,888	1,637
81	1,351	1,868	2,035	1,896	1,732	1,503	1,499	2,074	2,258	2,109	1,923	1,674
82	1,363	1,903	2,070	1,932	1,764	1,537	1,516	2,116	2,299	2,148	1,961	1,708
83	1,374	1,935	2,102	1,965	1,792	1,566	1,526	2,151	2,335	2,183	1,993	1,741
84	1,383	1,968	2,134	1,997	1,822	1,596	1,537	2,187	2,370	2,218	2,025	1,774
85	1,392	2,000	2,166	2,029	1,850	1,626	1,547	2,222	2,405	2,255	2,057	1,807
86	1,401	2,031	2,198	2,061	1,879	1,655	1,557	2,258	2,441	2,290	2,090	1,840
87	1,410	2,063	2,229	2,095	1,907	1,686	1,566	2,293	2,477	2,327	2,119	1,874
88	1,417	2,074	2,240	2,106	1,916	1,694	1,574	2,304	2,490	2,338	2,130	1,883
89	1,424	2,085	2,252	2,116	1,925	1,702	1,582	2,315	2,502	2,350	2,140	1,892
90	1,431	2,095	2,263	2,126	1,935	1,710	1,590	2,327	2,515	2,361	2,150	1,902
91	1,438	2,106	2,274	2,136	1,945	1,719	1,598	2,338	2,527	2,373	2,160	1,911
92	1,444	2,116	2,286	2,147	1,954	1,728	1,606	2,350	2,540	2,385	2,171	1,920
93	1,451	2,126	2,297	2,157	1,964	1,737	1,614	2,361	2,552	2,396	2,181	1,929
94	1,458	2,136	2,309	2,167	1,974	1,746	1,622	2,373	2,565	2,408	2,191	1,938
95	1,465	2,147	2,320	2,177	1,985	1,756	1,630	2,385	2,578	2,419	2,202	1,948
96	1,472	2,157	2,331	2,188	1,995	1,765	1,638	2,396	2,590	2,432	2,214	1,959
97	1,479	2,167	2,343	2,199	2,005	1,774	1,646	2,408	2,603	2,444	2,225	1,969
98	1,485	2,177	2,354	2,210	2,016	1,783	1,655	2,419	2,615	2,457	2,238	1,979
99	1,492	2,188	2,366	2,222	2,026	1,792	1,663	2,432	2,628	2,469	2,249	1,989

Modal Factors: Semi Annual: 0.5000

Quarterly: 0.25000

Monthly: .08333

PREMIUM INFORMATION

Heartland National Life Insurance Company may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as attained age, sex, underwriting class, state and zip code of residence.

Premiums are based on your attained age and will change on Your Policy Anniversary Date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of Policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

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 Heartland National Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your Policy, you may return it to: Heartland National Life Insurance Company, Medicare Supplement Administration, P.O. Box 10814, Clearwater, Florida 33757-8814. If you send the Policy back to us within 30 days after you receive it, we will treat the Policy as if it had never been issued and return all of your payments. **NOTE: The policy fee is fully refundable if the policy is not issued, delivery of the policy is refused or the policy is returned with the policy's 30-day free look period.**

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 Heartland National 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 *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. Heartland National Life Insurance Company 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.

Please refer to your Policy for details.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1132 All but \$283 a day All but \$566 a day \$0 \$0	\$0 \$283 a day \$566 a day 100% of Medicare eligible expenses \$0	\$1132 (Part A deductible) \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$141.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$141.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 copayment/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 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 \$162 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 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 \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (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 \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (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 PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1132 All but \$283 a day All but \$566 a day \$0 \$0	\$1132 (Part A deductible) \$283 a day \$566 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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 D

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

*Once you have been billed \$162 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 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 \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (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 \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN D
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN 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 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 PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1132 All but \$283 a day All but \$566 a day \$0 \$0	\$1132 (Part A deductible) \$283 a day \$566 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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 \$162 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 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 \$162 of Medicare Approved Amounts*	\$0	\$162 (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 \$162 of Medicare Approved amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN F
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$162 of Medicare Approved Amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN 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 PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1132 All but \$283 a day All but \$566 a day \$0 \$0	\$1132 (Part A deductible) \$283 a day \$566 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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 \$162 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 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 \$162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$162 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$162 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN G
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN 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 M

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 PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1132	\$566 (50% of Part A deductible)	\$566 (50% of Part A deductible)
61 st thru 90 th day	All but \$283 a day	\$283 a day	\$0
91 st day and after:			
— While using 60 lifetime reserve days	All but \$566 a day	\$566 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
21 st thru 100 th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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 M

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

*Once you have been billed \$162 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 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 \$162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$162 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$162 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN M
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN 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 PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1132 All but \$283 a day All but \$566 a day \$0 \$0	\$1132 (Part A deductible) \$283 a day \$566 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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 \$162 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 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 \$162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency 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.	\$162 (Part B deductible) Up to \$20 per office visit and up to \$50 per emergency 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 Next \$162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$162 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN N
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN 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.

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: Indianapolis, Indiana 46280

Medicare Supplement Administrative Office: PO Box 10812, Clearwater, FL 33757-8812

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

Application #:	
Applicant (Exactly as shown on your Medicare ID Card)	Residence Address:
Last	Street
First MI	City
Indicate the Medicare Supplement Plan Applied for:	State Zip Code
Plan: _____	Phone: (____) _____ - _____

SOCIAL SECURITY NUMBER	MEDICARE CLAIM NUMBER

AGE	DATE OF BIRTH	GENDER	HEIGHT	WEIGHT
	<i>Month Day Year</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female	____ ft ____ in	_____ lbs

PREMIUM PAYMENT	
Modal Premium: \$ _____	*Policy Fee: \$ _____
Total Submitted Premium: \$ _____	Requested Effective Date: _____
or <input type="checkbox"/> Draft Initial Premium	
*NOTE: The policy fee is refundable if the policy is not issued, taken, or if it is returned during the 30-day free look period.	

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT			
<input type="checkbox"/> Annual	<input type="checkbox"/> Semiannual	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly Bank Draft
<input type="checkbox"/> I authorize Bank Draft payments.	Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Amount to be drafted: \$ _____	
Bank Routing # (9 digits): _____	Bank Account # (do not include check #): _____	Select Bank Draft Day: (Cannot be more than 10 days beyond effective day)	
Bank Name: _____			
Name(s) of Depositor(s): _____			
Signature of Depositor: _____			Date: _____
Please include a voided check on a separate sheet of paper.			

PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

- 1. Have you used tobacco in any form in the past 12 months? Yes No
- 2. Are you covered under Medicare Part A? Yes No
If YES, what is your Part A effective date? ____ / ____ / ____
If NO, what is your eligibility date? ____ / ____ / ____
- 3. Are you covered under Medicare Part B? Yes No
If YES, what is your Part B effective date? ____ / ____ / ____
If NO, what is your eligibility date? ____ / ____ / ____
- 4. Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility). Yes No

MEDICARE & INSURANCE INFORMATION (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 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 our application. **PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X".**

To the best of your knowledge:

- 1. Did you turn age 65 in the last six months? Yes No
- 2. Did you enroll in Medicare Part B in the last six months? Yes No
If "Yes", what is the effective date? ____ / ____ / ____
- 3. 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, answer a-b below.
 - (a) Will Medicaid pay your premiums for this Medicare Supplement policy? Yes No
 - (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes No
- 4. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. (If you are still covered under the other policy, leave "END" blank.) Start ____ / ____ / ____ End ____ / ____ / ____
If YES, with which company _____
Company telephone number: _____ Policy number: _____
 - (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 plan to enroll in this Medicare plan? Yes No

MEDICARE & INSURANCE INFORMATION (Continued)

5. (a) Do you have another Medicare Supplement policy in force? Yes No
- (b) If yes with which company: _____
with which plan: _____
what paid-to-date do you have? ____/____/____
Company telephone number: _____
- (c) If yes, do you intend to replace your current Medicare Supplement policy with this policy? Yes No
6. 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 yes, with which company : _____
what kind of policy _____
what paid-to-date do you have? ____/____/____
Company telephone number: _____
- (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 ____/____/____

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

- (1) You do not need more than one Medicare Supplement Insurance 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 Insurance Policy.
- (4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance 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 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 suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy 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).

HEALTH QUESTIONS

Do not answer health questions 1-15 if you are in an open enrollment or guaranteed issue period. Please see page 6 for an explanation of open enrollment /guaranteed issue period information.

NOTICE TO APPLICANT: Please answer all of the following questions. Please verify the accuracy and completeness of the medical information on this application. Incomplete or false information on this application could jeopardize future claims. If you answer YES to any of the following questions 1 - 14, you are not eligible for coverage.

1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? Yes No
2. Within the past five years have you been diagnosed with or treated for emphysema, chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disorders? Yes No
3. Have you been diagnosed with Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with fractures, cirrhosis or kidney disease requiring dialysis? Yes No
4. Within the past five years, have you been diagnosed with or treated for Alzheimer's disease, senile dementia, or any other cognitive disorder? Yes No
5. Have you been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)? Yes No
6. Do you have, or in the last five years have you been diagnosed with diabetes in addition to any of the following: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), or kidney disease? Yes No
7. Do you have diabetes that has ever required more than 50 units of insulin daily? Yes No
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? Yes No
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? Yes No
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes No
11. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts? Yes No
12. Within the past five years, have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes No
13. Have you been hospital confined three or more times in the last two years? Yes No
14. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes No

HEALTH QUESTIONS Continued

15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If YES, please list the drug(s) below along with the date prescribed, dosage/frequency and diagnosis/medical condition for **each** medication. Attach a separate sheet if needed.

Yes No

Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/ Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	

PRIMARY CARE PHYSICIAN INFORMATION

Physician's Name: _____

Telephone Number: _____

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-15 on pages 4 and 5 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

- (a) Enrolled under an employee welfare benefit plan that either (1) provides health benefits that supplement the benefits under Medicare and the plan terminates or implements a material reduction of supplemental health benefits to the individual; or (2) is primary to Medicare and the plan terminates; or ceases to provide health benefits to the individual because the individual leaves the plan; or
- (b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation; or
- (e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment; or
- (f) Upon *first* becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

I certify that:

- 1. I have accurately recorded the information supplied by the Applicant; and
- 2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

Agent #1 Signature	Date	
Agent #1 Name (please print)	Agent #	Split %
Agent #2 Signature	Date	
Agent #2 Name (please print)	Agent #	Split %

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Heartland National Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Heartland National Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Heartland National Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Heartland National Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Heartland National Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Heartland National Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 10812, Clearwater, Florida 33757-8812. I understand that such revocation will not have any effect on actions Heartland National Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at: _____
State Applicant's Signature Date

This section to be completed by an agent.

Signed at: _____
State Writing Agent's Signature and Agent Number Date

Policy Mailing Preference: Mail to Agent Mail to Applicant

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

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: Indianapolis, Indiana 46280

Medicare Supplement Administrative Office: P. O. Box 10812 Clearwater, Florida 33757-8812

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 Heartland National Life Insurance Company. 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 AGENT: 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.
 - Change in benefits (Gaining additional benefit(s), but losing some existing benefit(s)).
 - 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) _____

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

Agent's Printed Name and Address

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature

Date

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Heartland National Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Heartland National Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Heartland National Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

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Signed at: _____
State Applicant's Signature Date

This section to be completed by an agent.

Signed at: _____
State Writing Agent's Signature and Agent Number Date

Policy Mailing Preference: Mail to Agent Mail to Applicant

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

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: Indianapolis, Indiana 46280

Medicare Supplement Administrative Office: P. O. Box 10812 Clearwater, Florida 33757-8812

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

Agent's Printed Name and Address

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature

Date

MSREPL2010

Leave with Applicant.

RECEIPT

All premium checks must be payable to: **Heartland National Life Insurance Company**.
Do not make checks payable to the agent or leave the Payee blank.
EFFECTIVE DATE will be the date of the application or the date of approval.

Received from _____
the sum of \$ _____ dollars for _____ months premium,
with application. If for any reason the application is not approved and the policy is not issued, this premium is to be refunded. No liability is created or assumed by the Company, except for refund of this premium, until the policy applied for has been issued.

Date Receipt and Outline of Coverage was prepared _____

By (Agent's Signature) _____