HEARTLAND NATIONAL
LIFE INSURANCE COMPANY
Medicare Supplement Administrative Office:
PO Box 10812, Clearwater, FL 33757-8812

APPLICATION FOR
MEDICARE SUPPLEMENT INSURANCE

TENNESSEE

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	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	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100 %)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out- of-pocket limit $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.**

Effective 05-01-2011

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

One-Time Policy Fee $25

TENNESSEE Standard Plans MALE Rates - ANNUAL

For use in zip codes: All zips except 370-372, 377-381

Attained Age	Non-Tobacco User						Attained Age	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	3,322	4,178	4,838	4,248	3,909	3,367	0-64	3,692	4,640	5,375	4,719	4,345	3,740
65	908	1,141	1,322	1,161	1,068	920	65	1,009	1,268	1,469	1,289	1,187	1,022
66	951	1,199	1,380	1,219	1,122	964	66	1,056	1,332	1,534	1,355	1,247	1,072
67	993	1,257	1,438	1,277	1,176	1,009	67	1,104	1,396	1,598	1,420	1,307	1,121
68	1,031	1,311	1,492	1,332	1,226	1,052	68	1,146	1,457	1,659	1,481	1,363	1,168
69	1,069	1,365	1,546	1,387	1,276	1,094	69	1,189	1,517	1,719	1,542	1,419	1,215
70	1,107	1,419	1,600	1,442	1,326	1,137	70	1,232	1,577	1,779	1,603	1,475	1,262
71	1,144	1,473	1,654	1,497	1,376	1,180	71	1,275	1,637	1,839	1,665	1,531	1,309
72	1,184	1,527	1,711	1,551	1,427	1,222	72	1,316	1,696	1,900	1,724	1,585	1,358
73	1,211	1,573	1,756	1,598	1,469	1,261	73	1,345	1,747	1,952	1,776	1,631	1,400
74	1,237	1,619	1,802	1,645	1,511	1,299	74	1,375	1,798	2,004	1,828	1,677	1,443
75	1,264	1,665	1,848	1,692	1,552	1,338	75	1,405	1,849	2,056	1,880	1,723	1,486
76	1,290	1,711	1,894	1,739	1,594	1,377	76	1,434	1,900	2,108	1,932	1,769	1,529
77	1,318	1,756	1,942	1,785	1,635	1,414	77	1,465	1,952	2,158	1,983	1,817	1,571
78	1,332	1,793	1,980	1,823	1,668	1,447	78	1,481	1,993	2,200	2,025	1,853	1,608
79	1,346	1,830	2,018	1,860	1,700	1,481	79	1,497	2,034	2,242	2,067	1,890	1,644
80	1,361	1,867	2,055	1,898	1,733	1,515	80	1,514	2,075	2,284	2,108	1,927	1,681
81	1,375	1,903	2,093	1,936	1,766	1,548	81	1,530	2,115	2,326	2,150	1,964	1,718
82	1,391	1,942	2,129	1,972	1,799	1,580	82	1,546	2,158	2,365	2,191	1,999	1,755
83	1,400	1,975	2,161	2,004	1,829	1,611	83	1,557	2,195	2,402	2,228	2,032	1,790
84	1,410	2,007	2,194	2,037	1,858	1,641	84	1,567	2,232	2,439	2,264	2,064	1,825
85	1,419	2,040	2,227	2,070	1,888	1,672	85	1,577	2,268	2,476	2,301	2,097	1,859
86	1,428	2,073	2,259	2,102	1,918	1,702	86	1,587	2,305	2,512	2,338	2,130	1,894
87	1,438	2,105	2,292	2,137	1,946	1,734	87	1,598	2,340	2,547	2,375	2,162	1,927
88	1,445	2,115	2,303	2,147	1,956	1,743	88	1,607	2,351	2,559	2,387	2,174	1,936
89	1,452	2,126	2,314	2,158	1,967	1,752	89	1,615	2,363	2,572	2,399	2,185	1,945
90	1,460	2,136	2,326	2,170	1,977	1,762	90	1,623	2,376	2,586	2,411	2,196	1,955
91	1,467	2,146	2,337	2,181	1,987	1,771	91	1,631	2,388	2,599	2,424	2,207	1,966
92	1,474	2,157	2,348	2,192	1,997	1,780	92	1,639	2,400	2,612	2,436	2,219	1,976
93	1,481	2,169	2,360	2,203	2,007	1,789	93	1,647	2,412	2,625	2,448	2,230	1,986
94	1,488	2,180	2,373	2,214	2,018	1,798	94	1,655	2,425	2,639	2,460	2,241	1,996
95	1,495	2,191	2,385	2,226	2,028	1,807	95	1,664	2,437	2,652	2,472	2,252	2,006
96	1,502	2,202	2,397	2,237	2,038	1,817	96	1,672	2,449	2,665	2,485	2,263	2,017
97	1,510	2,213	2,409	2,248	2,048	1,826	97	1,680	2,461	2,679	2,497	2,275	2,027
98	1,517	2,225	2,421	2,259	2,058	1,835	98	1,688	2,474	2,692	2,509	2,286	2,037
99	1,524	2,236	2,434	2,271	2,069	1,844	99	1,696	2,486	2,705	2,521	2,297	2,047

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: .08333

*For all applicants applying during open enrollment and during guarantee issue periods non-tobacco rates must be offered.

Effective 05-01-2011

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

One-Time Policy Fee $25

TENNESSEE Standard Plans MALE Rates - ANNUAL

For use in zip codes: 370-372, 377-381

Attained Age	Non-Tobacco User						Attained Age	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	3,713	4,669	5,407	4,748	4,368	3,763	0-64	4,127	5,186	6,008	5,274	4,856	4,180
65	1,015	1,276	1,477	1,297	1,194	1,028	65	1,127	1,417	1,642	1,441	1,327	1,142
66	1,062	1,340	1,542	1,362	1,254	1,078	66	1,180	1,489	1,714	1,514	1,394	1,198
67	1,110	1,404	1,607	1,427	1,314	1,127	67	1,233	1,561	1,786	1,587	1,460	1,253
68	1,153	1,465	1,668	1,489	1,370	1,175	68	1,281	1,628	1,854	1,655	1,523	1,305
69	1,195	1,525	1,728	1,550	1,426	1,223	69	1,329	1,695	1,921	1,724	1,586	1,358
70	1,237	1,586	1,789	1,612	1,482	1,271	70	1,377	1,762	1,988	1,792	1,648	1,410
71	1,279	1,646	1,849	1,674	1,538	1,319	71	1,425	1,830	2,055	1,860	1,711	1,463
72	1,324	1,707	1,912	1,734	1,595	1,366	72	1,471	1,896	2,124	1,927	1,772	1,517
73	1,353	1,758	1,963	1,786	1,642	1,409	73	1,504	1,953	2,182	1,985	1,823	1,565
74	1,383	1,809	2,014	1,839	1,688	1,452	74	1,537	2,010	2,240	2,043	1,874	1,613
75	1,412	1,860	2,066	1,891	1,735	1,496	75	1,570	2,067	2,298	2,101	1,925	1,661
76	1,442	1,912	2,117	1,944	1,782	1,539	76	1,603	2,124	2,356	2,159	1,977	1,709
77	1,473	1,963	2,171	1,995	1,827	1,580	77	1,637	2,182	2,412	2,216	2,030	1,756
78	1,489	2,004	2,213	2,037	1,864	1,618	78	1,655	2,228	2,459	2,263	2,071	1,797
79	1,505	2,045	2,255	2,079	1,900	1,655	79	1,674	2,273	2,506	2,310	2,112	1,838
80	1,521	2,086	2,297	2,122	1,937	1,693	80	1,692	2,319	2,552	2,356	2,153	1,879
81	1,537	2,127	2,339	2,164	1,973	1,731	81	1,710	2,364	2,599	2,403	2,195	1,920
82	1,555	2,171	2,379	2,204	2,011	1,766	82	1,728	2,412	2,644	2,449	2,234	1,962
83	1,565	2,207	2,416	2,240	2,044	1,800	83	1,740	2,453	2,685	2,490	2,271	2,001
84	1,575	2,244	2,452	2,277	2,077	1,834	84	1,751	2,494	2,726	2,531	2,307	2,039
85	1,586	2,280	2,489	2,313	2,110	1,868	85	1,762	2,535	2,767	2,572	2,344	2,078
86	1,596	2,316	2,525	2,350	2,143	1,903	86	1,774	2,576	2,808	2,613	2,380	2,117
87	1,607	2,353	2,562	2,388	2,175	1,938	87	1,786	2,615	2,847	2,654	2,417	2,153
88	1,615	2,364	2,574	2,400	2,187	1,948	88	1,796	2,628	2,860	2,668	2,429	2,164
89	1,623	2,376	2,587	2,412	2,198	1,959	89	1,805	2,641	2,875	2,681	2,442	2,174
90	1,631	2,387	2,599	2,425	2,209	1,969	90	1,814	2,655	2,890	2,695	2,454	2,185
91	1,639	2,399	2,612	2,437	2,221	1,979	91	1,823	2,669	2,905	2,709	2,467	2,197
92	1,647	2,411	2,624	2,450	2,232	1,989	92	1,832	2,682	2,920	2,722	2,480	2,208
93	1,655	2,424	2,638	2,462	2,244	2,000	93	1,841	2,696	2,934	2,736	2,492	2,220
94	1,663	2,436	2,652	2,475	2,255	2,010	94	1,850	2,710	2,949	2,750	2,505	2,231
95	1,671	2,449	2,665	2,487	2,266	2,020	95	1,859	2,723	2,964	2,763	2,517	2,242
96	1,679	2,461	2,679	2,500	2,278	2,030	96	1,868	2,737	2,979	2,777	2,530	2,254
97	1,687	2,474	2,693	2,513	2,289	2,041	97	1,878	2,751	2,994	2,791	2,542	2,265
98	1,695	2,486	2,706	2,525	2,301	2,051	98	1,887	2,765	3,008	2,804	2,555	2,277
99	1,703	2,499	2,720	2,538	2,312	2,061	99	1,896	2,778	3,023	2,818	2,567	2,288

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: .08333

*For all applicants applying during open enrollment and during guarantee issue periods non-tobacco rates must be offered.

Effective 05-01-2011

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

One-Time Policy Fee $25

TENNESSEE Standard Plans FEMALE Rates - ANNUAL

For use in zip codes: All zips except 370-372, 377-381

Attained Age	Non-Tobacco User					
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	2,890	3,636	4,211	3,695	3,401	2,930
65	789	993	1,151	1,010	929	801
66	827	1,043	1,201	1,061	976	839
67	864	1,093	1,252	1,112	1,023	878
68	898	1,140	1,298	1,160	1,067	915
69	931	1,187	1,345	1,208	1,111	952
70	965	1,234	1,392	1,256	1,155	988
71	999	1,281	1,439	1,304	1,199	1,025
72	1,030	1,328	1,488	1,349	1,241	1,063
73	1,054	1,368	1,529	1,390	1,278	1,097
74	1,077	1,408	1,570	1,431	1,315	1,130
75	1,101	1,447	1,611	1,472	1,352	1,164
76	1,124	1,487	1,651	1,513	1,388	1,197
77	1,146	1,528	1,690	1,552	1,423	1,230
78	1,160	1,561	1,723	1,585	1,451	1,259
79	1,173	1,593	1,755	1,618	1,480	1,287
80	1,186	1,626	1,788	1,650	1,509	1,316
81	1,200	1,659	1,821	1,683	1,537	1,344
82	1,211	1,689	1,852	1,716	1,566	1,375
83	1,219	1,718	1,881	1,744	1,591	1,401
84	1,227	1,746	1,909	1,773	1,617	1,428
85	1,235	1,775	1,938	1,801	1,642	1,455
86	1,243	1,803	1,967	1,830	1,668	1,481
87	1,252	1,832	1,994	1,859	1,693	1,509
88	1,258	1,841	2,004	1,869	1,701	1,516
89	1,264	1,850	2,015	1,878	1,710	1,523
90	1,270	1,859	2,025	1,887	1,718	1,530
91	1,276	1,869	2,035	1,896	1,726	1,538
92	1,282	1,878	2,045	1,905	1,734	1,546
93	1,288	1,887	2,055	1,915	1,743	1,554
94	1,294	1,896	2,066	1,924	1,752	1,563
95	1,301	1,905	2,076	1,933	1,762	1,571
96	1,307	1,915	2,086	1,942	1,771	1,579
97	1,313	1,924	2,096	1,952	1,780	1,587
98	1,319	1,933	2,106	1,962	1,789	1,595
99	1,325	1,942	2,117	1,973	1,798	1,603

Attained Age	Tobacco User					
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	3,211	4,039	4,678	4,107	3,778	3,256
65	877	1,104	1,278	1,122	1,032	889
66	919	1,159	1,334	1,179	1,085	932
67	960	1,215	1,390	1,235	1,137	975
68	997	1,267	1,443	1,288	1,185	1,016
69	1,033	1,319	1,496	1,341	1,233	1,057
70	1,070	1,371	1,549	1,394	1,281	1,098
71	1,107	1,423	1,602	1,447	1,329	1,138
72	1,144	1,476	1,653	1,499	1,379	1,181
73	1,170	1,521	1,698	1,544	1,420	1,218
74	1,195	1,566	1,743	1,589	1,461	1,255
75	1,221	1,611	1,788	1,634	1,501	1,291
76	1,246	1,655	1,833	1,679	1,542	1,328
77	1,274	1,698	1,878	1,725	1,581	1,367
78	1,288	1,734	1,914	1,762	1,613	1,399
79	1,303	1,770	1,949	1,798	1,644	1,432
80	1,317	1,805	1,985	1,835	1,676	1,465
81	1,331	1,841	2,021	1,872	1,707	1,497
82	1,345	1,878	2,057	1,906	1,740	1,528
83	1,355	1,909	2,089	1,938	1,769	1,558
84	1,364	1,941	2,121	1,970	1,797	1,587
85	1,373	1,973	2,152	2,001	1,826	1,617
86	1,382	2,004	2,184	2,033	1,854	1,646
87	1,390	2,035	2,216	2,066	1,881	1,677
88	1,397	2,045	2,228	2,076	1,890	1,685
89	1,405	2,055	2,239	2,086	1,899	1,693
90	1,412	2,066	2,250	2,096	1,908	1,701
91	1,419	2,076	2,261	2,106	1,918	1,710
92	1,426	2,086	2,273	2,117	1,927	1,718
93	1,433	2,096	2,284	2,127	1,936	1,726
94	1,440	2,106	2,295	2,137	1,945	1,734
95	1,447	2,117	2,306	2,147	1,955	1,743
96	1,455	2,127	2,317	2,158	1,966	1,752
97	1,462	2,137	2,329	2,170	1,976	1,762
98	1,469	2,147	2,340	2,181	1,986	1,771
99	1,476	2,158	2,351	2,192	1,996	1,780

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: .08333

*For all applicants applying during open enrollment and during guarantee issue periods non-tobacco rates must be offered.

Effective 05-01-2011

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

One-Time Policy Fee $25

TENNESSEE Standard Plans FEMALE Rates - ANNUAL

For use in zip codes: 370-372, 377-381

Attained Age	Non-Tobacco User						Attained Age	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	3,230	4,064	4,706	4,130	3,801	3,275	0-64	3,589	4,514	5,228	4,590	4,223	3,639
65	882	1,110	1,286	1,129	1,039	895	65	980	1,233	1,428	1,254	1,154	994
66	924	1,166	1,342	1,186	1,091	938	66	1,027	1,296	1,491	1,317	1,212	1,042
67	966	1,222	1,399	1,243	1,143	982	67	1,073	1,358	1,554	1,381	1,271	1,090
68	1,003	1,275	1,451	1,296	1,192	1,023	68	1,114	1,416	1,613	1,440	1,325	1,135
69	1,041	1,327	1,504	1,350	1,241	1,064	69	1,155	1,474	1,672	1,499	1,378	1,181
70	1,078	1,379	1,556	1,403	1,290	1,105	70	1,196	1,532	1,732	1,558	1,432	1,227
71	1,116	1,432	1,609	1,457	1,340	1,146	71	1,237	1,590	1,791	1,618	1,485	1,272
72	1,151	1,484	1,663	1,508	1,387	1,188	72	1,279	1,650	1,848	1,676	1,541	1,320
73	1,178	1,529	1,709	1,554	1,428	1,226	73	1,308	1,700	1,898	1,726	1,587	1,361
74	1,204	1,573	1,754	1,599	1,469	1,263	74	1,336	1,750	1,948	1,776	1,632	1,402
75	1,230	1,618	1,800	1,645	1,511	1,301	75	1,365	1,800	1,998	1,826	1,678	1,443
76	1,256	1,662	1,846	1,691	1,552	1,338	76	1,393	1,850	2,049	1,876	1,724	1,484
77	1,281	1,708	1,889	1,735	1,590	1,375	77	1,424	1,898	2,099	1,928	1,767	1,528
78	1,296	1,744	1,925	1,772	1,622	1,407	78	1,440	1,938	2,139	1,969	1,802	1,564
79	1,311	1,781	1,962	1,808	1,654	1,439	79	1,456	1,978	2,179	2,010	1,838	1,601
80	1,326	1,817	1,998	1,845	1,686	1,471	80	1,472	2,018	2,218	2,051	1,873	1,637
81	1,341	1,854	2,035	1,881	1,718	1,503	81	1,488	2,058	2,258	2,092	1,908	1,674
82	1,353	1,888	2,070	1,917	1,750	1,537	82	1,504	2,099	2,299	2,131	1,945	1,708
83	1,362	1,920	2,102	1,949	1,778	1,566	83	1,514	2,134	2,335	2,166	1,977	1,741
84	1,371	1,952	2,134	1,981	1,807	1,596	84	1,524	2,169	2,370	2,201	2,009	1,774
85	1,381	1,984	2,166	2,013	1,835	1,626	85	1,534	2,205	2,405	2,237	2,041	1,807
86	1,390	2,016	2,198	2,045	1,864	1,655	86	1,545	2,240	2,441	2,272	2,073	1,840
87	1,399	2,047	2,229	2,078	1,892	1,686	87	1,554	2,274	2,477	2,309	2,102	1,874
88	1,406	2,058	2,240	2,088	1,902	1,694	88	1,562	2,286	2,490	2,320	2,112	1,883
89	1,412	2,068	2,252	2,099	1,911	1,702	89	1,570	2,297	2,502	2,331	2,123	1,892
90	1,419	2,078	2,263	2,109	1,920	1,710	90	1,578	2,309	2,515	2,343	2,133	1,902
91	1,426	2,088	2,274	2,119	1,929	1,719	91	1,586	2,320	2,527	2,354	2,143	1,911
92	1,433	2,099	2,286	2,130	1,938	1,728	92	1,594	2,331	2,540	2,366	2,153	1,920
93	1,440	2,109	2,297	2,140	1,948	1,737	93	1,602	2,343	2,552	2,377	2,164	1,929
94	1,447	2,119	2,309	2,150	1,959	1,746	94	1,610	2,354	2,565	2,388	2,174	1,938
95	1,454	2,130	2,320	2,160	1,969	1,756	95	1,618	2,366	2,578	2,400	2,185	1,948
96	1,460	2,140	2,331	2,171	1,979	1,765	96	1,626	2,377	2,590	2,412	2,197	1,959
97	1,467	2,150	2,343	2,182	1,989	1,774	97	1,634	2,388	2,603	2,425	2,208	1,969
98	1,474	2,160	2,354	2,193	2,000	1,783	98	1,642	2,400	2,615	2,437	2,220	1,979
99	1,481	2,171	2,366	2,205	2,010	1,792	99	1,650	2,412	2,628	2,450	2,231	1,989

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: .08333

*For all applicants applying during open enrollment and during guarantee issue periods non-tobacco rates must be offered.

PREMIUM INFORMATION

Premiums are based on Your attained age and will change on Your Policy Anniversary Date. Your Policy Anniversary Date is the same month and day as the Policy Effective Date for each succeeding year this Policy remains in force. In addition, the premium may change 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. You will be notified at least thirty (30) days in advance before any change in the table of rates.

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.

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	All but $1132	$0	$1132 (Part A deductible)
61st thru 90th day	All but $283 a day	$283 a day	$0
91st 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
21st thru 100th day	All but $141.50 a day	$0	Up to $141.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for 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	All but $1132	$1132 (Part A deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st 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
21st thru 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 — Durable medical equipment First $162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $162 (Part B deductible) $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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 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	All but $1132	$1132 (Part A deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st 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
21st thru 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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	All but $1132	$1132 (Part A deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st 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
21st thru 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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*	$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	100%	$0
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 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)
61st thru 90th day	All but $283 a day	$283 a day	$0
91st 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
21st thru 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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*	$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 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 — Durable medical equipment First $162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $162 (Part B deductible) $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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 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	All but $1132	$1132 (Part A deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st 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
21st thru 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $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 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 — Durable medical equipment First $162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $162 (Part B deductible) $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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 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	
	Month *Day* *Year*	☐ Male	☐ Female

PREMIUM PAYMENT

Modal Premium: $ _____ Policy Fee: $ _____

Total Submitted Premium: $ _____ Requested Effective Date: _____

or ☐ Draft Initial Premium

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

☐ I authorize Bank Draft payments. Account Type: ☐ Checking ☐ 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. 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? _____/_____/_____

2. 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? _____/_____/_____

3. 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 reinstituted, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of 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 reinstituted, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of 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

You do not have to answer the following questions if you are in an open enrollment or guaranteed issue period. You may proceed to Page 7.

If you are not in an open enrollment or guaranteed issue period, please answer all of the following questions. Please see page 6 for an explanation of open enrollment and guaranteed issue period information.

Have you used tobacco in any form in the past 12 months? Yes ☐ No ☐

Height *Feet and inches* Weight *Pounds*

NOTICE TO APPLICANT: 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. Have you been diagnosed with 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. Have you been diagnosed with 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. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), or kidney disease? If you do **not** have diabetes, this question should be answered "NO." 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. 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 that has been prescribed or recommended by a physician? 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	

PRIMARY CARE PHYSICIAN INFORMATION

(You do not have to complete this information if you are applying during open enrollment or a guaranteed issue period.”)

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) supplements Medicare, and the plan terminates, or the plan ceases to provide all such benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all such supplemental health benefits to the individual; 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. Information obtained with this authorization can not be used during open enrollment or guaranteed issue period for risk rating or certificate (policy) issuance determinations.

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.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF COVERAGE.

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

MSREPL2010

Return to Company.

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. Information obtained with this authorization can not be used during open enrollment or guaranteed issue period for risk rating or certificate (policy) issuance determinations.

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.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF COVERAGE.

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

Leave with 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

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) _____