Underwritten by
CONTINENTAL GENERAL INSURANCE COMPANY

2004
Medicare Supplement

Outline of Coverage, Application and Rate Booklet

Agent: Jerry Hill 82994

MEDICARE SUPPLEMENT INSURANCE APPLICATION TO

- CONTINENTAL GENERAL INSURANCE COMPANY -

6201 Johnson Drive – P. O. Box 29136 – Mission, KS 66201-9136

Name of Proposed Insured (Print) Last First Initial	Sex	Birthdate Mo. Day Year	Age	Social Security No.	Medicare Card No.
Resident Street Address (No P.O. Box)	City		State	Zip	Telephone No.
Premium Payor Address (if other than the insured)	City		State	Zip	Telephone No.

COVERAGE APPLIED FOR

Check plan selected:

☐ Plan A
☐ Plan B
☐ Plan C
☐ Plan D
☐ Plan E
☐ Plan F
☐ Plan G
☐ Plan F* (High Deductible)
☐ __________ (Other)

Check premium payment mode selected:

☐ Annual
☐ Semi-Annual
☐ Quarterly
☐ Monthly BOM
☐ ______________ (Other)

Amount of Premium Submitted with the Application: $__________ (Check must be made payable to Continental General Insurance Company).

OPEN ENROLLMENT – FEDERAL LAW REQUIRES THAT A 6-MONTH OPEN ENROLLMENT PERIOD BE PROVIDED TO AN APPLICANT WHO IS: (1) AGE 65 OR OLDER WHEN FIRST ENROLLING IN MEDICARE PART B; OR (2) AGE 65 AND PREVIOUSLY ENROLLED IN MEDICARE PART B; OR (3) UNDER AGE 65 WHEN FIRST ENROLLING IN MEDICARE PART B (APPLIES TO PLAN A ONLY). IF APPLICANT QUALIFIES FOR OPEN ENROLLMENT, DO NOT ANSWER THE FOLLOWING MEDICAL QUESTIONS IN A.

A. If the answer to any question in this section is “Yes” the proposed insured is not eligible for coverage.

	Yes	No
1. Are you currently confined in a hospital or nursing facility, or receiving the services of a home health agency?	☐	☐
2. Has surgery been advised but not performed?	☐	☐
3. Is surgery anticipated within the next 12 months?	☐	☐
4. Are you bedridden or do you use the assistance of a wheelchair or walker?	☐	☐
5. Within the past two years have you:		
a. Been confined to a nursing facility?	☐	☐
b. Been hospitalized more than 2 times?	☐	☐
c. Had any amputation caused by disease?	☐	☐

6. Do you have now, or have you received medical advice, treatment, or been advised to have treatment, surgery, or take medication for the following conditions:

A) At any time for:

	Yes	No
1. Parkinson’s Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Dementia, or Alzheimer’s Disease or Organic Brain Disorder?	☐	☐
2. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human immunodeficiency virus (HIV) infection?	☐	☐

B) Within the past two (2) years for: Yes No

1. Insulin Dependent Diabetes, Uncontrolled Diabetes, Chronic Kidney Disease, Renal Insufficiency, Renal Failure, or any Kidney Disease requiring dialysis? .... ☐ ☐
2. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic Obstructive Lung Disease (COLD) excluding Asthma, or any Chronic Pulmonary Disease Requiring the use of oxygen? .... ☐ ☐
3. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma? ☐ ☐
4. Heart Attack, Heart or Heart Valve Surgery, Congestive Heart Failure, Peripheral Vascular Disease, Aneurysm, or Cardiac Pacemaker or Defibrillating Device? .... ☐ ☐
5. Stroke or Transient Ischemic Attack (TIA)? .... ☐ ☐
6. Cirrhosis of the Liver, Hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment? .... ☐ ☐
7. Alcohol or Drug Abuse? .... ☐ ☐
8. Paget's Disease, Rheumatoid or Disabling Arthritis, Lupus or other bone or Connective tissue disorder? .... ☐ ☐

Phone interviews will be used on the non-open enrollee/Guarantee Issue applicants. Daytime Phone #________________

- You do not need more than one Medicare supplement policy.
- If you purchased this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- The benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the State Medicaid program, including benefits in Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

B. Do you have another Medicare supplement policy or certificate inforce? .... ☐ Yes ☐ No

1. If so, with which company? ____________________
2. Effective date of existing coverage ____________________.
3. Do you intend to replace your current Medicare supplement policy with this policy? .... ☐ Yes ☐ No
4. Date this policy is to be terminated ____________________. Policy # ____________________

If existing Medicare supplement coverage is not to be replaced, this policy cannot be issued.

C. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy? .... ☐ Yes ☐ No

1. If so, with which company? ____________________
2. What kind of policy? ____________________

D. Are you covered for medical assistance through the **State Medicaid** program? .... ☐ Yes ☐ No

1. As a specified Low-Income Medicare Beneficiary (SLMB)? .... ☐ Yes ☐ No
2. As a Qualified Medicare Beneficiary (QMB)? (if yes, coverage cannot be issued.) .... ☐ Yes ☐ No
3. For other Medicaid medical benefits? .... ☐ Yes ☐ No

E. Do you now have Medicare Parts A and B? .... ☐ Yes ☐ No
If yes, give effective date of Part B: ________________________________.

F. If Medicare Parts A and B are to be effective at a future date, provide the date both Medicare Parts A and B will be effective ________________________.

NOTE – Medicare effective date is always the 1st day of the month**. Applicant must have both Medicare Parts A & B on the effective date of the policy. If not, coverage cannot be issued.**

I have received the Outline of Coverage for the policy applied for and the required Guide to Health Insurance for People with Medicare .... ☐ YES ☐ NO

I hereby apply to Continental General Insurance Company, Mission, Kansas, for insurance to be issued upon the truth and completeness of the answers to the above questions to the best of my knowledge, and agree that: (1) No agent has the authority to waive the answer to any question in the application; and (2) no insurance will be effective until a policy has been issued.

AUTHORIZATION

I hereby authorize any health care provider, including any physician, practitioner, pharmacy, hospital or medically-related facility, and any insurance company, employer, or, except in AZ and WI, any other organization, institution or person that has my records or knowledge of me or my dependent(s) to disclose to Continental General Insurance Company (CGI), or its authorized representative, any such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by Company personnel to determine eligibility for insurance and/or benefits. CGI may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. CGI reserves the right to require a medical examination or testing or both. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask CGI to correct, amend or delete any incorrect personal information. A copy of the Company's "Privacy Notice and Notice of Insurance Information Practices" is available upon request.

This authorization shall be valid for a period of two (2) years (one [1] year in Kansas) from the date signed to determine eligibility for insurance or for the term of coverage of the policy to determine benefits. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to the Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke also is subject to the rights of the Company under any law granting the Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

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 may be guilty of a crime and may be subject to fines and confinement in prison.

Signature of Applicant: ____________ Date: ____________

Signature of Authorized Representative: ____________ Relationship/ Authority to Represent ____________ Date: ____________

11811 East Freeway, Suite 545 * Houston, Texas 77029

Authorized Representative's Address:

Phone 713-455-7087 * Toll Free 1-800-926-9107

Authorized Representative's Phone Number:

INVESTIGATIVE CONSUMER REPORTS AUTHORIZATION

As part of our normal procedure for processing your application, an investigative consumer report may be prepared whereby information is obtained as to the character, general reputation, personal characteristics and mode of living of persons proposed for insurance in this application. Personal interviews with friends, neighbors and associates may be used to develop this report. (In WV, no information collected concerning the sexual orientation of the proposed insured will be used to determine his or her eligibility for insurance.) You may request to be interviewed in connection with the preparation of the report. Upon written request, you or your representatives have a right to receive a copy of the report and additional information about the nature and scope of the investigation.

AGENT'S CERTIFICATE

1. List the health policies you sold to this applicant which are still in force: (If this does not apply, state NONE).

2. List any other health policies or coverages you sold to this applicant which are no longer in force: (If this does not apply, state NONE).

3. (a) Have you reviewed the application for correctness and omissions? .... ☐ YES ☐ NO
   (b) Was application completed by you in the applicant's presence? .... ☐ YES ☐ NO
   (c) Do you have knowledge or reason to believe the replacement of existing insurance may be involved? .... ☐ YES ☐ NO

If "YES" give Name of Company, reason and termination date

I certify that I saw the applicant and truly and accurately recorded, in the applicant's presence, all the information supplied me by the applicant.

Signature of Licensed Resident Agent Jerry Hill / ____________ # 82994
Print Name Signature

CAUTION: Please review your answers to the questions on this application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

Application No.___________________

Applicant_________________________

(Please Print)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

CONTINENTAL GENERAL INSURANCE COMPANY
Mailing Address:
6201 Johnson Drive
P.O. Box 29136 • Mission, Kansas 66201-9136

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

According to (your application or information you have furnished), you intend to lapse or otherwise terminate existing Medicare supplement insurance and replace it with a policy to be issued by Continental General Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep this policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing 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 coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE):
(Use additional sheets, as necessary)

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 coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason. (Check one):

_______ Additional benefits.

_______ Same benefits, but lower premiums.

_______ Fewer benefits and lower premiums.

_______ Other (Please Specify).

____

____

____

I call to your attention the following items for your consideration:

(1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the issuer 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, READ IT CAREFULLY TO BE CERTAIN THAT ALL INFORMATION HAS BEEN PROPERLY RECORDED.**

(4) **DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.**

____

(Signature of Agent, Broker or Other Representative)

____

(Typed Name and Address of Agent or Broker)

____

(Date)

____

(Applicant’s Signature)

APPLICANT’S COPY

Application No.___________________

Applicant_________________________

(Please Print)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

CONTINENTAL GENERAL INSURANCE COMPANY
Mailing Address:
6201 Johnson Drive
P.O. Box 29136 • Mission, Kansas 66201-9136

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

According to (your application or information you have furnished), you intend to lapse or otherwise terminate existing Medicare supplement insurance and replace it with a policy to be issued by Continental General Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep this policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing 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 coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT (OR OTHER REPRESENTATIVE):
(Use additional sheets, as necessary)

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 coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason. (Check one):

________ Additional benefits.

________ Same benefits, but lower premiums.

________ Fewer benefits and lower premiums.

________ Other (Please Specify).

____

____

____

I call to your attention the following items for your consideration:

(1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the issuer 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, READ IT CAREFULLY TO BE CERTAIN THAT ALL INFORMATION HAS BEEN PROPERLY RECORDED.**

(4) **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 or Other Representative)

____

(Typed Name and Address of Agent or Issuer)

____

(Date)

____

(Applicant’s Signature)

CERTIFICATION

I, the undersigned insurance agent certify:

THAT, I have taken an application for Policy Form No. ____________ Offered by the Continental General Insurance Company, to ______________________ .
Applicant

THAT, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of $ ____________________ which has been paid to me by
(Insert zero if no premium received)

( ) Check ( ) Cash ( ) Money Order .
(Check appropriate method of payment)

THAT, I have clearly explained any benefits of this plan that are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Health Care Financing Administration of the Federal Government in connection with this insurance policy being applied for.

______________________ Date	______________________ Signature of Agent
I, the undersigned applicant, have received a copy of this form	______________________ Name of Agency
	______________________ Address of Agent or Agency
	______________________ Address of Agent or Agency
______________________ Applicant's signature	______________________ Phone No.

Form Cert.-Texas

CERTIFICATION

I, the undersigned insurance agent certify:

THAT, I have taken an application for Policy Form No. ____________ Offered by the Continental General Insurance Company, to ______________________ .
Applicant

THAT, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of $ ____________________ which has been paid to me by
(Insert zero if no premium received)

(   ) Check   (   ) Cash   (   ) Money Order   .
(Check appropriate method of payment)

THAT, I have clearly explained any benefits of this plan that are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Health Care Financing Administration of the Federal Government in connection with this insurance policy being applied for.

______________________	______________________
Date	Signature of Agent

I, the undersigned applicant, have received a copy of this form

____
Name of Agency

____
Address of Agent or Agency

____
Address of Agent or Agency

______________________	______________________
Applicant's signature	Phone No.

Form Cert.-Texas

HOME OFFICE COPY

IMPORTANT NOTICE

CHANGE IN MEDICARE — GUARANTEED ISSUE TO ELIGIBLE PERSONS MEDICARE SUPPLEMENT REQUIREMENTS

(BALANCED BUDGET ACT OF 1997)

GUARANTEED ISSUE CRITERIA

Eligible persons are those individuals who apply for coverage generally not later than 63 days after the date of termination of:

(a) an Employee Welfare Benefit Plan;
(b) a Medicare+ Choice Plan;
(c) a Medicare Cost plan (or similar organization);
(d) a Program of All-Inclusive Care for the Elderly (PACE);
(e) a Medicare Supplement policy; or
(f) a Medicare Select plan;

and who submits evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

We are not permitted to: (a) deny or condition the issuance or effectiveness of a Medicare supplement policy, that is offered and available for issuance to new applicants by us; (b) discriminate in the pricing of such Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; and (c) impose an exclusion of benefits based on a pre-existing condition under a Medicare supplement policy.

DEFINITIONS

An Eligible Person is:

1. An individual who is enrolled/insured under an employee welfare benefit plan that provides health benefits that supplement Medicare benefits; and the plan terminates; or, the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates, or ceases to provide all health benefits to the individual because the individual leaves the plan.
2. The individual is enrolled with a Medicare+ Choice organization under a Medicare+ Choice plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare+Choice Plan:
   a. The organization's or plan's certification (under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D) has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
   b. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in a disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;
   c. The individual demonstrates, in accordance with guidelines established by the Secretary, that:
      i. The organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or
      ii. The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
   d. The individual meets such other exceptional conditions as the Secretary may provide.
3. The individual is enrolled with:
   a. An eligible organization under a contract under Section 1876 (Medicare cost);
   b. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
   c. An organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or
   d. An organization under a Medicare Select policy.

   Enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under item 2 above.
4. An individual who is insured under a Medicare supplement policy and enrollment ceases because:
   a. of the insolvency of the insurer or bankruptcy of the noninsurer organization; or
   b. of other involuntary termination of coverage or enrollment under the policy.

5. a. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+ Choice organization under a Medicare+ Choice plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and
   b. The subsequent enrollment is terminated by the enrollee during any period within the 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the Social Security Act); or
6. The individual, upon first becoming eligible for benefits under Part B of Medicare at age 65 or older, enrolls in a Medicare+ Choice plan under Part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan by not later than 12 months after the effective date of enrollment.

SUMMARY — GUARANTEED ISSUE PROCEDURES

*** GENERALLY MUST APPLY WITHIN 63 DAYS OF TERMINATION OF PRIOR CREDITABLE COVERAGE**

*** APPLICANT MUST BE COVERED UNDER BOTH MEDICARE PARTS A AND B**

A. EMPLOYEE WELFARE BENEFITS TERMINATING. Employee Welfare Benefit Plan must terminate or cease all retiree supplemental health benefits. Requirements for issue:
   1. statement from employer verifying all supplemental health benefits for all retirees are being terminated;
   2. date such coverage began (if not on the letter, it must be entered on the application by the agent);
   3. date of termination of existing coverage; and
   4. that applicant is “retired” (not working).

B. MEDICARE COST CONTRACT (HMO OR SIMILAR ORGANIZATION).
   1. Terminating contract (in whole or in specific areas). Requirements for issue:
      Copy of letter from issuer which was sent to the enrollee (our applicant) specifying:
      a. date of enrollment (if not on the letter, it must be entered on the application by the agent);
      b. date of termination; and
      c. reason for termination.
   2. The applicant no longer resides in the HMO’s or MCP’s service area. Requirements for issue:
      Copy of letter from issuer to enrollee (our applicant) specifying:
      a. reason for disenrollment;
      b. date of enrollment (if not on the letter, it must be entered on the application by the agent); and
      c. date of termination;
      OR
      d. a copy of disenrollment form completed by applicant which was sent to issuer providing all information requested in *Requirements for issue* (2a) above, and previous address of applicant.

C. MEDICARE SELECT CONTRACT. Same provisions as B above are applicable, EXCEPT a statement from the Medicare Select insurer stating that there is not a provision in the state law for continuation of such coverage is required.

D. MEDICARE+ CHOICE CONTRACT.
   1. Same provisions as B above are applicable, EXCEPT annual election does not apply (this is voluntary).
   2. A person previously insured under a traditional Medicare supplement policy may enroll in a Medicare+ Choice plan and such individual may return to the same insurer within 12 months for guarantee issue of the previous plan (if available) or a similar plan.

   (NOTE: Applicable only if never before enrolled in a Medicare+ Choice plan. If the prior insurer is no longer solvent, another traditional Medicare supplement insurer is required to issue such individual on a medicare supplement policy.)

E. TRADITIONAL MEDIGAP POLICIES.
   1. The applicant has elected to terminate a Medicare supplement policy due to cause (see “eligible person” definition). Requirements for issue:
      a. statement from insurer or insurance department to verify reason to terminate coverage;
      b. date prior coverage was effective (if not on the statement, it must be entered on the application by the agent); and
      c. date of termination.
   2. Insolvency of insurer — applicant must provide us with a statement or letter from the insolvent company or insurance department.

QUALIFYING EVENT	FOR THESE REASONS	PLANS AVAILABLE UNDER GUARANTEED ISSUE
Initial Medicare eligibility at age 65	Individual enrolls in Medicare+Choice or with a PACE provider and terminates enrollment during the first 12 months.	All policies (A-J)
Individual terminates Medigap coverage to try Medicare+Choice or PACE provider	Individual enrolls for first time in Medicare+Choice plan, or similar demonstration, with a PACE provider or Medicare Select; and such enrollment is terminated during first 12 months.	Same insurer and same policy as before. (If not available, then plans A, B, C, and F or comparable plans in waivered states.*)
Employer coverage ceases	Plan terminates or ceases all supplemental benefits to individual.	A, B, C, and F (or comparable plans in waivered states.*)
Medicare+Choice plan enrollment or PACE coverage is discontinued	Plan is leaving Medicare program or stops giving care in individual's area; individual moves out of service area; plan violated or misrepresented contract; or other per Secretary, Department of Health and Human Services (HHS).	A, B, C, and F (or comparable plans in waivered states.*)
Medicare Cost, Medicare Select, or demo coverage is discontinued	Plan is leaving Medicare program or stops giving care in individual's area; individual moves out of service area; plan violated or misrepresented contract or other per Secretary of HHS — and, in the case of Medicare Select, there is no state law provision for continuation or conversion of coverage.	A, B, C, and F (or comparable plans in waivered states.*)
Medigap coverage ceases	Insurer bankrupt or other involuntary termination and there is no state law provision for continuation or conversion of coverage; plan violated contract or misrepresented provisions in marketing.	A, B, C, and F (or comparable plans in waivered states.*)

* Waivered states are Massachusetts, Minnesota, and Wisconsin

CONTINENTAL GENERAL INSURANCE COMPANY
Mailing Address: 6201 Johnson Drive, P.O. Box 29136, Mission, Kansas 66201-9136
Outline of Medicare Supplement Coverage — Cover Page
BENEFIT PLANS A, B, C, D, F, E, F* AND G ARE BEING OFFERED IN YOUR STATE

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses) or in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments.)
Blood: First three pints of blood each year.

A	B	C	D	E	F / F*	G	H	I	J / J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		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	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 Limit) Limit)	Basic Drugs ($1,250 Limit) Limit)	Extended Drugs ($3,000 Limit)
				Preventive Care					Preventive Care

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year $1690 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are $1690. 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 does not include, in plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

CONTINENTAL GENERAL INSURANCE COMPANY

Mailing Address: 6201 Johnson Drive, P.O. Box 29136, Mission, Kansas 66201-9136

TEXAS
MEDICARE SUPPLEMENT

Attained Age Annual Premiums — 2004 Level
Female

Attained Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	High Deductible Plan F
0-64	$3,019							
65	1,503	$1,253	$1,744	$1,261	$1,006	$1,591	$1,312	$491
66	1,567	1,307	1,819	1,314	1,048	1,658	1,369	511
67	1,625	1,355	1,885	1,363	1,087	1,719	1,421	531
68	1,691	1,410	1,961	1,418	1,131	1,789	1,477	552
69	1,755	1,464	2,038	1,472	1,174	1,856	1,534	572
70	1,819	1,517	2,112	1,526	1,217	1,925	1,590	594
71	1,884	1,570	2,186	1,579	1,259	1,991	1,644	615
72	1,941	1,621	2,254	1,630	1,300	2,054	1,697	634
73	1,997	1,665	2,318	1,674	1,335	2,112	1,744	652
74	2,048	1,706	2,376	1,718	1,370	2,164	1,788	669
75	2,097	1,748	2,431	1,758	1,402	2,217	1,830	684
76	2,134	1,782	2,477	1,790	1,428	2,258	1,864	698
77	2,174	1,813	2,523	1,823	1,454	2,299	1,900	710
78	2,217	1,849	2,572	1,858	1,482	2,345	1,936	723
79	2,257	1,881	2,619	1,894	1,510	2,388	1,971	737
80	2,296	1,915	2,666	1,927	1,537	2,429	2,006	750
81	2,335	1,948	2,709	1,958	1,562	2,469	2,039	762
82	2,373	1,979	2,754	1,989	1,586	2,510	2,072	775
83	2,410	2,009	2,796	2,021	1,612	2,548	2,103	787
84	2,445	2,039	2,837	2,051	1,635	2,587	2,135	798
85	2,476	2,066	2,873	2,077	1,656	2,620	2,163	808
86	2,507	2,092	2,909	2,103	1,677	2,653	2,191	819
87	2,539	2,118	2,946	2,130	1,698	2,686	2,218	829
88	2,571	2,145	2,983	2,156	1,720	2,720	2,246	839
89	2,603	2,172	3,021	2,184	1,742	2,754	2,274	850
90	2,641	2,203	3,065	2,215	1,767	2,794	2,307	862
91	2,681	2,236	3,110	2,248	1,793	2,836	2,342	875
92	2,721	2,270	3,157	2,282	1,821	2,879	2,377	888
93	2,762	2,304	3,205	2,317	1,848	2,922	2,413	902
94	2,805	2,340	3,255	2,353	1,877	2,968	2,451	916
95	2,849	2,377	3,306	2,390	1,906	3,015	2,489	930
96	2,895	2,415	3,359	2,428	1,936	3,063	2,529	945
97	2,942	2,454	3,413	2,467	1,968	3,112	2,570	960
98	2,980	2,486	3,457	2,499	1,993	3,152	2,603	973
99	3,019	2,518	3,502	2,532	2,019	3,194	2,637	985

The Following Apply:

1. Area Factors

Zip Code	Factor
770-775	1.30
750-753	1.20
761	1.10
776-777, 793-794	1.15
Else	0.95

2. Males - add 11.5%
3. Tobacco User Surcharge — None
4. All adjustment factors are multiplicative.
5. Mode Factors
   - Semi-Annual .0.520
   - Quarterly 0.265
   - Monthly Direct 0.090
   - Monthly Bank Draft 0.085
6. Add an additional $25 administration fee to the initial premium.

PLANS A, B, C, D, E, F, F* AND G

1. **GUARANTEED RENEWABLE:** As long as premiums are paid when due, the policy will be renewed for life.

2. **PREMIUM INFORMATION:** Your premium will change each year based on your attained age. We can also change your premium when: • we make the same change to all policies of this Form in the state where you live; or • we change the Table of Premiums for all policies of this Form in the same geographic area of the state where you live; or • the benefits of the policy change due to a change in Medicare benefits. Premium changes based on where you live or on a revised Table of Premiums or due to change in Medicare benefits will be effective on the next Renewal Date.

   Policy Form: ______________________________ Premium $ ______________________________

   Mode of Payment: Annual ________ Semi-Annual ________
   Quarterly ________ Monthly ________
   Monthly B.O.M. ________

3. **DISCLOSURES:** Use this outline to compare benefits and premiums among policies.

4. **READ YOUR POLICY VERY CAREFULLY:** This is only an outline which describes 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 Continental General Insurance Company.

5. **RIGHT TO RETURN POLICY:** If you are not satisfied with Your policy, You may return it to Us at the address shown on Page 1. If You send it 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 Your payments.

6. **EXCLUSIONS:** Unless specifically stated otherwise, the policy does not cover or consider for payment any service or supply or any portion of a service or supply that is not a Medicare Eligible Expense, nor will the policy duplicate any benefit paid by Medicare.

7. **REFUND OF PREMIUM:** The policies do not provide for a refund of premium upon death or surrender of the policy.

8. **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.

9. **NOTICE:** This policy may not fully cover all Your medical costs.

Neither Continental General 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.

10. **COMPLETE ANSWERS ON APPLICATION 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. The 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.

PLANS A, B & C (Policy Forms 3AA, 3AB & 3AC)
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.

**$0 indicates your liability for covered charges. You are responsible for all non-covered charges.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $876	$0	$876 (Part A Deductible)
61st thru 90th day	All but $219 a day	$219 a day	$0**
91st day and after:			
—While using 60 lifetime reserve days	All but $438 a day	$438 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 $109.50 a day	$0	Up to $109.50 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			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer (CGI) stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 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 B PAYS	YOU PAY	PLAN C PAYS	YOU PAY
$876 (Part A Deductible) $219 a day $438 a day 100% of Medicare Eligible Expenses $0	$0** $0** $0** $0** All Costs	$876 (Part A Deductible) $219 a day $438 a day 100% of Medicare Eligible Expenses $0	$0** $0** $0** $0** All Costs
$0 $0 $0	$0** Up to $109.50 a day All Costs	$0 Up to $109.50 a day $0	$0** $0** All Costs
3 Pints $0	$0** $0**	3 Pints $0	$0** $0**
$0	Balance	$0	Balance

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer (CGI) stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 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.

PLANS A, B & C (Policy Forms 3AA, 3AB & 3AC)
MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

*Once you have been billed $100 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.

**$0 indicates your liability for covered charges. You are responsible for all non-covered charges.

SERVICES	MEDICARE PAYS	PLAN A 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 $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Part B Coinsurance or Copayments For Hospital Outpatient Services	$0**
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 Pints	$0	All Costs	$0**
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0**
CLINICAL LABORATORY SERVICES			
BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0**

PLANS A, B & C (Policy Forms 3AA, 3AB & 3AC)
MEDICARE PARTS A AND B

*Once you have been billed $100 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.

**$0 indicates your liability for covered charges. You are responsible for all non-covered charges.

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

PLAN B PAYS	YOU PAY	PLAN C PAYS	YOU PAY
$0 Part B Coinsurance or Copayments For Hospital Outpatient Services $0	$100 (Part B Deductible) $0** All Costs	$100 (Part B Deductible) Part B Coinsurance or Copayments For Hospital Outpatient Services $0	$0** $0** All Costs
All Costs $0 20%	$0** $100 (Part B Deductible) $0**	All Costs $100 (Part B Deductible) 20%	$0** $0** $0**
$0	$0**	$0	$0**

$0 $0 20%	$0** $100 (Part B Deductible) $0**	$0 $100 (Part B Deductible) 20%	$0** $0** $0** $0**
$0 $0	$250 All Costs	$0 80% to a lifetime maximum amount of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

PLANS D, E, F & G (Policy Forms 3AD, 3AE, 3AF & 3AG)
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.

**$0 indicates your liability for covered charges. You are responsible for all non-covered charges.

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $876	$876 (Part A Deductible)	$0**
61st thru 90th day	All but $219 a day	$219 a day	$0**
91st day and after:			
—While using 60 lifetime reserve days	All but $438 a day	$438 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 $109.50 a day	Up to $109.50 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer (CGI) stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 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 E PAYS	YOU PAY	PLAN F PAYS	YOU PAY
$876 (Part A Deductible) $219 a day $438 a day 100% of Medicare Eligible Expenses $0	$0** $0** $0** $0** All Costs	$876 (Part A Deductible) $219 a day $438 a day 100% of Medicare Eligible Expenses $0	$0** $0** $0** $0** All Costs
$0 Up to $109.50 a day $0	$0** $0** All Costs	$0 Up to $109.50 a day $0	$0** $0** All Costs
3 Pints $0	$0** $0**	3 Pints $0	$0** $0**
$0	Balance	$0	Balance

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer (CGI) stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 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 PAYS	YOU PAY
$876 (Part A Deductible) $219 a day $438 a day 100% of Medicare Eligible Expenses $0	$0** $0** $0** $0** All Costs
$0 Up to $109.50 a day $0	$0** $0** All Costs
3 Pints $0	$0** $0**
$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted,the insurer (CGI) stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 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.

PLANS D, E, F & G (Policy Forms 3AD, 3AE, 3AF & 3AG)
MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

*Once you have been billed $100 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.

**$0 indicates your liability for covered charges. You are responsible for all non-covered charges.

SERVICES	MEDICARE PAYS	PLAN D 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 $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Part B Coinsurance or Copayments For Hospital Outpatient Services	$0**
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 Pints	$0	All Costs	$0**
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0**
CLINICAL LABORATORY SERVICES			
BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0**

PLAN E PAYS	YOU PAY	PLAN F PAYS	YOU PAY
$0 Generally 20% $0	$100 (Part B Deductible) $0** All Costs	$100 Part B Deductible) Part B Coinsurance or Copayments For Hospital Outpatient Services 100%	$0** $0** $0**
All Costs $0 20%	$0** $100 $0**	All Costs $100 Part B Deductible) 20%	$0** $0** $0**
$0	$0**	$0	$0**

PLAN G PAYS	YOU PAY
$0 Part B Coinsurance or Copayments For Hospital Outpatient Services 80%	$100 (Part B Deductible) $0** 20%
All Costs $0 20%	$0** $100 (Part B Deductible) $0**
$0	$0**

PLANS D, E, F & G (Policy Forms 3AD, 3AE, 3AF & 3AG)
MEDICARE PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
HOME HEALTH CARE **MEDICARE APPROVED SERVICES**			
— Medically necessary skilled care services and medical supplies	100%	$0	$0**
— Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0**
AT HOME RECOVERY SERVICES — **NOT COVERED BY MEDICARE** Home care certified by your doctor for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits not to exceed 7 each week	
—Calendar year maximum	$0	$1600	

OTHER BENEFITS — NOT COVERED BY MEDICARE

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 amount of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E PAYS	YOU PAY	PLAN F PAYS	YOU PAY
$0 $0 20%	$0** $100 (Part B Deductible) $0**	$0 $100 (Part B Deductible) 20%	$0** $0** $0**
$0 $0 $0	All Costs All Costs	$0 $0 $0	All Costs All Costs

$0 80% to a lifetime maximum amount of $50,000	$250 20% and amounts over the $50,000 lifetime maximum	$0 80% to a lifetime maximum amount of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

PLAN G PAYS	YOU PAY
$0 $0 20%	$0** $100 (Part B Deductible) $0
Actual Charges to $40 a visit Up to the number of Medicare approved visits not to exceed 7 each week $1600	Balance

$0 80% to a lifetime maximum amount of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F (Policy Form 3AK)
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.

**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year $1690 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $1690.Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

***$0 indicates your liability for covered charges. You are responsible for all non-covered charges.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1690 DEDUCTIBLE,** PLAN F PAYS	IN ADDITION TO $1690 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $876	$876 (Part A Deductible)	$0***
61st thru 90th day	All but $219 a day	$219 a day	$0***
91st day and after:			
—While using 60 lifetime reserve days	All but $438 a day	$438 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 $109.50 a day	Up to $109.50 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			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer (CGI) stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 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.

HIGH DEDUCTIBLE PLAN F (Policy Form 3AK)
MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

*Once you have been billed $100 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.
**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year $1690 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $1690.Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

***$0 indicates your liability for covered charges. You are responsible for all non-covered charges.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1690 DEDUCTIBLE,** PLAN F PAYS	IN ADDITION TO $1690 DEDUCTIBLE,** 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 $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0***
Remainder of Medicare Approved Amounts	Generally 80%	Part B Coinsurance or Copayment For Hospital Outpatient Services	$0***
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0***
BLOOD			
First 3 Pints	$0	All Costs	$0***
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0***
Remainder of Medicare Approved Amounts	80%	20%	$0***
CLINICAL LABORATORY SERVICES			
BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0***

HIGH DEDUCTIBLE PLAN F (Policy Form 3AK)
MEDICARE PARTS A AND B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1690 DEDUCTIBLE,** PLAN F PAYS	IN ADDITION TO $1690 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0***
— Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0***
Remainder of Medicare Approved Amounts	80%	20%	$0***

OTHER BENEFITS — NOT COVERED BY MEDICARE

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 amount of $50,000	20% and amounts over the $50,000 lifetime maximum

OFFICIAL RECEIPT

CHECK OR MONEY ORDER MUST ACCOMPANY APPLICATION

Received of ______________________________ this __________ day of ________________, an application for a Form __________ Policy and Check
Month Year
or Money Order for ____________________________________ Dollars.
Should the Company decline to issue the insurance applied for, the Company hereby agrees to return the above sum to the applicant.

______________________________ Agent

If the full premium is paid with the application and so recorded in the application and the Company shall be satisfied after investigation that the applicant was acceptable for the insurance applied for at the time the application was signed according to the underwriting rules of the Company the policy will be dated and effective according to its terms at 12:01 A.M. the day the application was dated or the date on which the premium was paid, whichever is later.

CONTINENTAL GENERAL INSURANCE COMPANY
Mailing Address:6201 Johnson Drive • PO Box 29136 • Mission,KS 66201-9136 • 913-722-1110

BANK AUTHORIZATION

CONTINENTAL GENERAL INSURANCE COMPANY is hereby requested and authorized to draw checks to be charged against the checking account of:

____
(print name as shown on bank records) (account number)

with ______________________________
(name of bank and branch name, if any) (transit no. #)

____
(address of bank or branch where account is maintained)

for the purpose of collecting premiums payable to CONTINENTAL GENERAL INSURANCE COMPANY under the bank check premium arrangement. The policy(ies) are to be placed under the bank check premium arrangement, upon approval by the Company, for premiums due.

It is understood that CONTINENTAL GENERAL INSURANCE COMPANY'S premium arrangement may be terminated by the policy owner or by the Company upon written notice.

(Date) ____________ ______________________
(signature of policy owner)

Authorization to honor checks drawn by Continental General Insurance Company, Omaha, Nebr.

to

______________ ______________
(name of bank depositor) (name of bank and branch name, if any)

______________ ______________
(account no.#) (address of bank or branch where account is maintained)

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn by Continental General Insurance Company to its own order. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check.

I agree that your treatment of each such check, and your rights in respect to it, shall be the same as if it were signed personally by me. I further agree that if any such check be dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Continental General Insurance Company is instructed to forward this authorization to you.

__________ ______________________
date (signature of bank depositor—as shown on bank records for the account to which this authorization is applicable)

INDEMNIFICATION AGREEMENT

To: The Bank Named Above

In consideration of your participation in a plan which the CONTINENTAL GENERAL INSURANCE COMPANY has put in effect by which amounts for premiums due on policies of insurance are collected by drafts drawn by the company on the accounts of persons who have made themselves responsible for these payments, the Company does hereby agree that subject to the terms and provisions of such insurance policies without varying, extending or altering the terms, thereof:

(1) It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any check drawn by the Company on the account of such person, or arising out of the dishonor by you, whether with or without cause or intentionally or inadvertently, of any such check drawn by the Company, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture, of a policy of insurance the premium on which is sought to be collected by the Company by any such check; and

(2) It will refund to you any amount erroneously paid by you on any such check if claim for the amount of such erroneous payment is made by you within a reasonable time from the date of the check on which such erroneous payment was made.

____
(authorized Officer's signature) President

Please Note: A VOIDED check must accompany the authorization.

CGI

CONTINENTAL GENERAL
INSURANCE COMPANY