MEDICARE SUPPLEMENT
MEDICARE SELECT

APPLICATION PACKAGE

Standard Life and Accident Insurance Company

Administrative Office: P.O. Box 1870
Galveston, Texas 77553-1870

1.888.350.1488

A Member of the American National Family of Companies

MEDICARE SUPPLEMENT APPLICATION *(Please Print — Use Black Ink)*

Jerry Hill / M-0753

MEDICARE SUPPLEMENT APPLICATION TO STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, ADMINISTRATIVE OFFICE: P.O. BOX 1870, GALVESTON, TEXAS 77553-1870

SECTION A

1. Applicant _____ Birthdate _____ Age _____
   Home Address _____ City _____ State _____ Zip _____
   Phone (_____) _____
2. Billing Address (if different) _____ City _____ State _____ Zip _____
3. Height _____ Weight _____

SECTION B

New Policy ❑ Reinstatement ❑

4. Plan _____ Standard ❑ SELECT ❑ Male ❑ Female ❑ Non Tobacco User ❑ Tobacco User ❑
5. a) Requested Effective Date _____
   b) Payment Mode: Annual ❑ Semiannual ❑ Quarterly ❑ Monthly COM ❑

SECTION C

To the best of your knowledge:

6. Are you currently covered or will you be covered within the next 30 days by Part A and Part B of Medicare?
   Yes ❑ **No** ❑
   If "Yes", give full Medicare claim number from your Medicare card _____
   Effective Date of Part A _____ Part B _____
   If "No", this policy will not be issued.
7. Do you currently have another Medicare Supplement policy or certificate in force?
   Yes ❑ **No** ❑
   If "Yes" give company name, number, type of plan, and date to which premiums are paid.
   _____
   _____
   Do you intend to replace the policy or certificate listed above with this policy, if issued?
   Yes ❑ **No** ❑
   If "Yes", submit replacement form.
   If "No", this policy will not be issued.
8. Do you have any other health insurance coverage that provides benefits similar to this Medicare Supplement policy?
   Yes ❑ **No** ❑
   If "Yes" give company name and type of policy.
   _____
   _____
9. Are you covered for medical assistance through the state Medicaid program?
   a) as a Specified Low-Income Medicare Beneficiary (SLMB)?
      Yes ❑ **No** ❑
   b) as a Qualified Medicare Beneficiary (QMB)?
      Yes ❑ **No** ❑
   c) for other Medicaid medical benefits?
      Yes ❑ **No** ❑

If the answer to Questions 10 or 11 in Section C is "Yes", do not complete Section D.

10. Do you qualify for open enrollment?
    Yes ❑ **No** ❑
11. Do you qualify for guaranteed issue?
    Yes ❑ **No** ❑

    Please refer to the application supplement for definitions regarding open enrollment and guarantee issue.

SECTION D

If the answer to any question in Section D (12-15h) is "Yes", the application should not be submitted.

12. Are you now bedridden, confined to a nursing home, assisted living facility, hospital or receiving the services of a home health care agency?
    Yes ❑ **No** ❑
13. Within the past **10 years**, have you been treated for or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection?
    Yes ❑ **No** ❑
14. Within the last **2 years**, have you:
    a) had or been recommended to have medical tests or treatment or surgery which have not been done or for which results have not been given?
       Yes ❑ **No** ❑

continued

b) been hospitalized 2 or more times or confined to a nursing home or required assistance or supervision by another person for dressing, eating, personal hygiene (bathing or toileting), walking or transferring to or from a bed or chair or suffered a fracture of the spine or hip?
Yes ❑ **No** ❑

c) required the use of a wheelchair, walker or cane?
Yes ❑ **No** ❑

d) been advised to have cataract surgery or other eye surgery that has not been performed?
Yes ❑ **No** ❑

15. Do you now have or within the past **2 years** have you had or been advised to have treatment, surgery or to take prescription medication for:

a) cancer (excluding basal or squamous cell), Hodgkin's disease, leukemia, or melanoma; even if the conditions are in remission?
Yes ❑ **No** ❑

b) congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder, heart disease, enlarged heart, heart attack, transient ischemic attack, stroke, heart rhythm disorders, heart or heart valve surgery, angioplasty, bypass, pacemaker, or stent placement?
Yes ❑ **No** ❑

c) uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene?
Yes ❑ **No** ❑

d) emphysema, asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen?
Yes ❑ **No** ❑

e) ulcerative colitis, Crohn's disease, cirrhosis of the liver, hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment?
Yes ❑ **No** ❑

f) Paget's disease, osteoporosis, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder?
Yes ❑ **No** ❑

g) mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, seizure disorders, senile dementia or other senility disorders or alcohol or drug abuse?
Yes ❑ **No** ❑

h) incontinence, any ostomy present, amputation due to disease, an organ transplant other than corneal?
Yes ❑ **No** ❑

16. Within the past **2 years**, have you consulted a physician, been diagnosed or received treatment for any condition not listed above, including dizziness or vertigo?
Yes ❑ **No** ❑

If "Yes", give information regarding diagnosis or condition.

_____

_____

SECTION E

The Applicant must read the following statements or the Agent must read the following statements to the Applicant.

You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare 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 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 as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

SECTION F

AGREEMENT — I have read or had read to me my completed application (including the statements in **Section E**). My answers are true and complete. I understand my coverage, if issued, will begin on the date of issue shown in my policy. I realize any false statement or misrepresentation in my application may result in loss of coverage under my policy.

ACKNOWLEDGMENT — I have received the outline of coverage and Guide to Health Insurance for People with Medicare from the Agent.

Applicant's Signature _____

City _____ State _____ Zip _____

Date Signed _____

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retreival services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:

1) such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations;
2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
3) a picture copy or photocopy of this authorization shall be as valid as the original; and
4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. I may inspect or copy any information used or disclosed under this authorization, if signed.

_____ _____

Date Applicant's Signature

_____ _____

Witness Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee representative, other _____ (Circle one)

AGENT'S STATEMENT

I certify that: 1) I saw the Applicant; 2) I asked the Applicant the questions in the application and truly and accurately recorded the answers; 3) the answers did not conflict with my observations and knowledge of the Applicant; 4) I witnessed the Applicant's signature; and 5) I gave the outline of coverage and Guide to Health Insurance for People with Medicare to the Applicant and, if appropriate, a copy of the replacement form and the Medicare SELECT Description of Benefits.

I also certify that: 1) the Applicant has read, or had read to him or her, the completed application (including the statements in Section E); and 2) the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

The company names, policy numbers and types of coverages of any other health insurance policies that I sold to the Applicant and which are currently in force are (if none, write "NONE"). _____

_____

The company names, policy numbers and types of coverages of any other health insurance policies that I sold to the Applicant during the last 5 years and which are not currently in force are (if none, write "NONE"). _____

_____

Agent's Code M-0753

Amount Collected by Agent: _____
(including the $20 application fee)

Agent's Signature _____

Receipt Given: Yes ❑ No ❑

Mail Policy to: Insured ❑ Agent ❑

A TELEPHONE INTERVIEW WILL BE MADE

What will be the best time to contact the Applicant for the telephone interview? _____

_____

_____

Special Requests _____

AUTHORIZATION TO MY BANK

CHECK-O-MATIC AUTHORIZATION

Attach Voided Check or Deposit Ticket Here and Sign Authorization

Bank Information

_____
Name

_____ _____ _____
City State Zip

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to 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 further agree that if any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____ ✓_____
Date Signed Signature (as it appears on bank records)

Complete for Savings Accounts only if no personalized savings deposit ticket is available.

Account No. _____

Routing No. _____

Standard Life and Accident Insurance Company
P.O. Box 1820
Galveston, TX 77553-1820

APPLICATION SUPPLEMENT FOR MEDICARE SUPPLEMENT PLANS

Are you eligible for Medicare Supplement Open Enrollment? If you apply for this policy prior to or during the six-month period beginning with the first day of the first month in which you turned 65, you are eligible for open enrollment. If you buy this policy during your Medicare Supplement open enrollment period and you had a continuous period of creditable coverage for at least six months, no pre-existing condition waiting period will apply. If you had less than six months of continuous creditable coverage, this waiting period will be reduced by the number of months of creditable coverage you had.

"Continuous Period of Creditable Coverage" means the period during which you have been covered by creditable coverage, if during the period of the coverage you had no breaks in coverage greater than sixty-three (63) days from the date of application for this policy.

"Creditable Coverage" means with respect to an individual, coverage you were provided under any one of the following:

1) A group health plan;
2) Health insurance coverage;
3) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;
5) Chapter 55 of Title 10 United States Code (TRICARE);
6) A medical care program of the Indian Health Service or of a tribal organization;
7) A state health benefits risk pool;
8) A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9) A public health plan as defined in federal regulation; and
10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

Creditable coverage does not include one or more, or any combination of, the following: 1) coverage only for accident or disability income insurance, or any combination thereof; 2) coverage issued as a supplement to liability insurance; 3) liability insurance, including general liability insurance and automobile liability insurance; 4) workers' compensation or similar insurance; 5) automobile medical payment insurance; 6) credit-only insurance; 7) coverage for on-site medical clinics; and 8) other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Creditable coverage will not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: 1) limited scope dental or vision benefits; 2) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and 3) such other similar, limited benefits as are specified in federal regulations. Creditable coverage will not include the following benefits if offered as independent, non-coordinated benefits: 1) coverage only for a specified disease or illness; and 2) hospital indemnity or other fixed indemnity insurance. Creditable coverage will not include the following if it is offered as a separate policy, certificate or contract of insurance: 1) Medicare supplemental health insurance as defined under section 1882 (g)(1) of the Social Security Act; 2) coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (TRICARE); and 3) similar supplemental coverage provided under a group health plan.

continued

Standard Life and Accident Insurance Company
P.O. Box 1820
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Are you eligible for Guaranteed Issue? The following are definitions of the categories of individuals who are eligible for Guarantee Issue if they enroll under a Medicare Supplement policy during specific time periods. If any of the definitions apply to you, indicate which one below and submit the appropriate documentation, including notice of termination or disenrollment.

1) You are enrolled under an employee welfare benefit plan that either: a) supplements Medicare, and the plan terminates, or the plan ceases to provide all such benefits, or b) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to you because you leave the plan;

2) You are enrolled in a Medicare+Choice plan or you are under 65 years of age or older and are enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider plan and specific circumstances permit discontinuance, including, but not limited to: a) the certification of the plan has been terminated, or b) the plan is terminated or discontinued in the area where you reside, or c) you have a change in residence and are no longer eligible to elect the plan, or d) the plan substantially violated a material provision of the plan's contract in relation to your coverage, or e) the plan or their representatives materially misrepresented the plan's provisions in marketing the plan to you;

3) You are enrolled in a Medicare cost contract or similar organization, a health care prepayment plan or Medicare SELECT policy and specific circumstances permit discontinuance, including, but not limited to: a) the certification of the plan has been terminated, or b) the plan is terminated or discontinued in the area where you reside, or c) you have a change in residence and are no longer eligible to elect the plan, or d) the plan substantially violated a material provision of the plan's contract in relation to your coverage, or e) the plan or their representatives materially misrepresented the plan's provisions in marketing the plan to you;

4) You are enrolled in a Medicare Supplement policy and coverage discontinues due to: a) insolvency, or b) involuntary termination of coverage or enrollment under the policy, or c) substantial violation of a material policy provision, or d) the plan or their representatives materially misrepresented the policy's provisions in marketing the policy to you;

5) You are enrolled under a Medicare Supplement policy and you terminate enrollment and subsequently enroll, for the first time, in a Medicare+Choice plan, Medicare cost contract or similar organization, any PACE provider plan, or a Medicare SELECT plan, and you terminate coverage during the first 12 months of enrollment; or

6) You, upon first becoming enrolled for benefits under Medicare Part B at age 65 or older, enroll in a Medicare+Choice plan or with a PACE provider plan and then disenroll from the plan no later than 12 months after the effective date of enrollment.

CHECK ONE:

_____ I am not eligible for Open Enrollment or Guaranteed Issue.

_____ I am eligible for Open Enrollment or Guaranteed Issue under category _____ above.

_____
Date

_____
Proposed Insured's Signature

Jerry Hill
_____
Agent's Signature

Standard Life and Accident Insurance Company
P.O. Box 1820
Galveston, TX 77553-1820

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

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

According to your application, you intend to terminate existing Medicare Supplement coverage and replace it with a policy to be issued by Standard Life and Accident Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the 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. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare Supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY AGENT

I have reviewed your current medical or health 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 reasons:

— 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:

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 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 and 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.

Jerry Hill
_____
Agent's Signature

Jerr Hill - 11811 East Freeway, Suite 545 * Houston, Texas 77029
_____
Printed Name and Address of Agent

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

_____
Applicant's Signature

Standard Life and Accident Insurance Company
P.O. Box 1820
Galveston, TX 77553-1820

MEDICARE SELECT INSURANCE POLICY DISCLOSURE

I acknowledge I have received the following provisions, restrictions and limitations which apply to the Medicare SELECT insurance policy:

1) An outline of coverage;
2) A description of the restricted network provisions, including:
   a) a description of the current network hospitals (including address, phone number and hours of operation);
   b) payments for deductibles when hospitals other than network hospitals are utilized;
   c) coverage for emergency and urgently needed care and other out-of-service area coverage;
   d) limitations on referral to restricted network hospitals;
   e) description of my rights to purchase any other Medicare Supplement insurance policy offered by Standard Life;
   f) Standard Life's Quality Assurance Program; and
   g) Standard Life's Grievance Procedure.

Only certain hospitals are network providers under this policy. Check with your physician to determine if he or she has admitting privileges at the network hospital. If he or she does not, you may be required to use another physician at the time of hospitalization or you will be required to pay for all expenses.

I have received a full and fair disclosure of the information described above.

Applicant's Signature

Date Signed

Jerry Hill

Agent's Signature

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P.O. Box 1820
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— Fewer benefits and lower premiums.
— Other (please specify). _____

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

Health conditions which you may presently have (pre-existing 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.

State law provides that your replacement policy may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing 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.

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 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 and 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.

Jerry Hill
_____
Agent's Signature

_____
Printed Name and Address of Agent

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

_____
Applicant's Signature

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P.O. Box 1820
Galveston, TX 77553-1820

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Jerry Hill
_____
Agent's Signature

_____
Printed Name and Address of Agent

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

_____
Applicant's Signature

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Jerry Hill
_____
Agent's Signature

_____
Printed Name and Address of Agent

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

_____
Applicant's Signature

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RECEIPT

CHECK OR MONEY ORDER FOR INITIAL PREMIUM MUST ACCOMPANY APPLICATION. ALL CHECKS AND MONEY ORDERS MUST BE PAYABLE TO STANDARD LIFE AND ACCIDENT INSURANCE COMPANY. If a policy is not issued, the initial premium will be refunded to the Applicant. If a policy is issued, coverage will begin on the date of issue shown in the policy.

Received from _____ on _____
Date

an application for Plan _____ and a Check ❑ Money Order ❑ for $ _____
(including the $20 application fee)

Applicant's Signature _____

Agent's Signature Jerry Hill

DISCLOSURE NOTICE

In connection with your application, Standard Life and Accident Insurance Company, or its reinsurers, may obtain medical and other information for evaluation purposes. Standard Life may obtain that information from the Medical Information Bureau, Inc. or any medical professional, medically related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given you or your family. That information could concern drugs, alcoholism or mental illness. Standard Life may also obtain an investigative consumer report on you.

Information you provide will be treated as confidential. Standard Life or its reinsurers may make a brief report to the Medical Information Bureau. The Bureau is a non-profit organization. It operates an information exchange in behalf of its members who are life insurance companies. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which you submit a claim, the Bureau will supply such company with the information it may have in its files. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone (617) 426-3660. Standard Life or its reinsurers may also make a brief report regarding you or your family to other companies to whom you have applied or may apply.

If an investigative consumer report is prepared in connection with your application, you may request to be interviewed for that report. Also, you have the right to review and note any corrections concerning reported personal information in Standard Life's file, unless the information is privileged.

This notice is only a summary. You may request additional information about Standard Life's information collection practices and your rights by contacting Standard Life.

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY • P.O. Box 1820 • Galveston, Texas 77553-1820 • (888) 350-1488

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Standard Life and Accident Insurance Company
P.O. Box 1820
Galveston, TX 77553-1820

MEDICARE SELECT INSURANCE POLICY DISCLOSURE

I acknowledge I have received the following provisions, restrictions and limitations which apply to the Medicare SELECT insurance policy:

1) An outline of coverage;
2) A description of the restricted network provisions, including:
   a) a description of the current network hospitals (including address, phone number and hours of operation);
   b) payments for deductibles when hospitals other than network hospitals are utilized;
   c) coverage for emergency and urgently needed care and other out-of-service area coverage;
   d) limitations on referral to restricted network hospitals;
   e) description of my rights to purchase any other Medicare Supplement insurance policy offered by Standard Life;
   f) Standard Life's Quality Assurance Program; and
   g) Standard Life's Grievance Procedure.

Only certain hospitals are network providers under this policy. Check with your physician to determine if he or she has admitting privileges at the network hospital. If he or she does not, you may be required to use another physician at the time of hospitalization or you will be required to pay for all expenses.

I have received a full and fair disclosure of the information described above.

_____ _____

Applicant's Signature | Date Signed

Jerry Hill

_____

Agent's Signature

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DESCRIPTION OF BENEFITS
MEDICARE SUPPLEMENT SELECT INSURANCE POLICY

I) Description of Medicare SELECT Program

We will pay full benefits if you receive Medicare approved treatment in a network hospital participating as a preferred provider approved by the Plan, which establishes a network of approved groups of health care facilities.

Medicare SELECT policies include restricted network provisions. You must use providers who participate in a network program to receive full Medicare Supplement benefits. If your doctor does not have admitting privileges to a network hospital, you must have your doctor refer you to another doctor who has admitting privileges. Or, if you choose, you may select another doctor who can submit you to a network hospital.

We may pay reduced benefits if you are treated outside of the approved groups. The reduced benefits require you to pay the initial Part A deductible amount if you are hospitalized in a non-approved hospital. Payment for covered expenses will not be restricted if the services are for symptoms requiring emergency care, or are immediately required for an unforeseen condition and it is not reasonable to obtain such services through a network provider.

II) Medicare SELECT Outline of Coverage

The Medicare SELECT Outline of Coverage contains a summary of benefits and premium rates. Use the outline to compare coverage and premiums with other Medicare Supplement policies offered by Standard Life or other companies.

III) Provider Network

There is an attached list that includes names, addresses and telephone numbers of network providers. Preferred providers are available twenty-four (24) hours each day, seven (7) days a week.

IV) Quality Assurance Program

All network hospitals must be approved for reimbursement of Medicare benefits. They must also satisfy the criteria established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

V) Grievance Procedure

We have a customer service program which can provide information to you, handle your complaints and help satisfy your concerns.

If you are unhappy with the response received to a complaint, you may submit a formal grievance with us. All grievances will be addressed immediately and resolved as soon as possible. Each level of the grievance process is handled by a person with problem-solving authority. All concerned parties will be notified about the results of a grievance. If a grievance is found valid, corrective action will be promptly taken. If you are dissatisfied with the decision, you have the right to appeal to the Texas Department of Insurance.

continued

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Grievances While Staying At A Network Hospital

If you have a grievance regarding us or a network hospital's treatment or services while you are confined at that hospital, you may contact our Grievance Manager at 1-800-899-6510 or submit a written request to:

Standard Life and Accident Insurance Company
c/o Grievance Appeal Manager
P.O. Box 1999
Galveston, Texas 77550-1999

Grievances relating to ongoing hospital treatment will be addressed immediately on receipt of any oral or written grievance, and resolved as quickly as possible in a manner that does not interfere with, obstruct or interrupt continued proper medical treatment and care.

Any Other Grievance

All other grievances must be presented in written form and must contain the words "THIS IS A GRIEVANCE" or other words that clearly state the intention of the written communication. A physician, other than your primary care physician, must be involved in reviewing any medically related grievances. A grievance providing complete details must be submitted in writing to:

Standard Life and Accident Insurance Company
c/o Grievance Appeal Manager
P.O. Box 1999
Galveston, Texas 77550-1999

We will mail you notice that we have received the written grievance within five (5) days after receipt. The grievance will be investigated and a response will be sent within a maximum of forty-five (45) days after being received by us. The response will explain in detail the reasons for the determination.

VI) Continuation and Conversion

In the event that regulators determine that Medicare SELECT policies issued should be discontinued due to either the failure of the Medicare SELECT program to be re-authorized or its substantial amendment, we will continue your coverage for a period of one year from the date we are notified of such discontinuance. Following the one-year period, your Medicare SELECT policy is converted to a Medicare Supplement policy offered by us which has comparable or lesser benefits and which does not contain a restricted network.

If you decide not to participate in our participating hospital network, you may convert your Medicare SELECT policy to any Medicare Supplement policy offered by us with comparable or lesser benefits and which does not contain a restricted network provision. You will not have to provide evidence of insurability if your current policy has been in force for more than 90 days.

VII) Purchase of Other Medicare Supplement Policies

You have the right to purchase any other Medicare Supplement policy we offer in your state of residence at the time of application for the Medicare SELECT plan.