Forethought Life Insurance Company Administrative Office P.O. Box 14659, Clearwater, FL 33766-4659 (877) 492-5870

Outline of Medicare Supplement Coverage – Cover Page

The Commissioner of Insurance of the State of Minnesota has established two categories of Medicare Supplements and minimum standards for each, with the extended basic Medicare Supplement being the most comprehensive and the basic Medicare Supplement being the least comprehensive. This chart shows the benefits in each plan. Additional Benefits are shown on page 16.

Basic—
Policy Form MSBA10-01-MN

Hospitalization: Part A Coinsurance

Medical Expenses: Part B Coinsurance

Blood: First 3 pints of blood each year

Skilled Nursing Coinsurance

Part A Deductible *
Part B Deductible *
Part B Excess *

Foreign Travel

Hospice Care

Preventive Care *

Extended Basic—
Policy Form MSXT10-01-MN

Hospitalization: Part A Coinsurance

Medical Expenses: Part B Coinsurance

Blood: First 3 pints of blood each year

Skilled Nursing Coinsurance

Part A Deductible
Part B Deductible
Part B Excess (100%)

Foreign Travel

Hospice Care

Preventive Care *

$20 and $50 Copayment—
Policy Form MSCO10-01-MN

Hospitalization: Part A Coinsurance

Medical Expenses: Part B Coinsurance except up to $20 copayment for office visit, and up to $50 copayment for ER

Blood: First 3 pints of blood each year

Skilled Nursing Coinsurance for the 21st through 100th day

Part A Deductible

Foreign Travel

Hospice Care

Premium Information

We, Forethought Life Insurance Company, will renew the policy each time you pay us the premium. It must be paid by the date it is due or during the 31 days that follow. Your policy stays in force during this 31-day period. Your premium cannot be changed unless we make the same change on all policies of this form owned by persons in your classification which are renewed in the state where you live at the time we change the premium. Any such change can be made on any renewal date. Schedules of rates may vary depending on your Policy Date. You will be notified 30 days in advance of a premium change.

"Persons in Your Classification" means all persons having the same benefits.

* Optional Riders available for Part A Deductible, Part B Excess, Medicare Part B Deductible and Preventive Health Services.

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Forethought Life Insurance Company Administrative Office P.O. Box 14659, Clearwater, FL 33766-4659 (877) 492-5870

MONTHLY PREMIUMS

ZIP CODES: 559-567

NON-TOBACCO - MONTHLY RATES		TOBACCO - MONTHLY RATES	
Basic - Policy Form MSBA10-01 MN		**Basic - Policy Form MSBA10-01 MN**	
ALL AGES	$115.95	ALL AGES	$133.28
Optional Riders		Optional Riders	
Medicare Part A Deductible Rider MS2010A-01-MN	$23.27	Medicare Part A Deductible Rider MS2010A-01-MN	$26.75
Medicare Part B Deductible Rider MS2010B-01-MN	$13.50	Medicare Part B Deductible Rider MS2010B-01-MN	$13.50
Preventive Medical Care Benefits Rider MS2010PC-01-MN	$5.44	Preventive Medical Care Benefits Rider MS2010PC-01-MN	$6.25
Medicare Part B Excess Charges Rider MS2010BX-01-MN	$3.77	Medicare Part B Excess Charges Rider MS2010BX-01-MN	$4.33
Extended Basic - Policy Form MSXT10-01-MN		**Extended Basic - Policy Form MSXT10-01-MN**	
ALL AGES	$324.08	ALL AGES	$372.51
$20 and $50 Copayment Plan - Policy Form MSCO10-01-MN		**$20 and $50 Copayment Plan - Policy Form MSCO10-01-MN**	
ALL AGES	$117.35	ALL AGES	$134.89

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively.

The policy provides an anticipated loss ratio of 72%. This means that, on the average, Policyholders may expect that $72.00 of every $100.00 in premium will be returned as benefits to Policyholders over the life of the contract.

Forethought Life Insurance Company Administrative Office P.O. Box 14659, Clearwater, FL 33766-4659 (877) 492-5870

MONTHLY PREMIUMS

ZIP CODES: 550, 553, 555-558

NON-TOBACCO - MONTHLY RATES		TOBACCO - MONTHLY RATES	
Basic - Policy Form MSBA10-01 MN		**Basic - Policy Form MSBA10-01 MN**	
ALL AGES	$132.18	ALL AGES	$151.94
Optional Riders		Optional Riders	
Medicare Part A Deductible Rider MS2010A-01-MN	$26.53	Medicare Part A Deductible Rider MS2010A-01-MN	$30.50
Medicare Part B Deductible Rider MS2010B-01-MN	$13.50	Medicare Part B Deductible Rider MS2010B-01-MN	$13.50
Preventive Medical Care Benefits Rider MS2010PC-01-MN	$6.20	Preventive Medical Care Benefits Rider MS2010PC-01-MN	$7.13
Medicare Part B Excess Charges Rider MS2010BX-01-MN	$4.30	Medicare Part B Excess Charges Rider MS2010BX-01-MN	$4.94
Extended Basic - Policy Form MSXT10-01-MN		**Extended Basic - Policy Form MSXT10-01-MN**	
ALL AGES	$369.45	ALL AGES	$424.66
$20 and $50 Copayment Plan - Policy Form MSCO10-01-MN		**$20 and $50 Copayment Plan - Policy Form MSCO10-01-MN**	
ALL AGES	$133.78	ALL AGES	$153.77

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively.

The policy provides an anticipated loss ratio of 72%. This means that, on the average, Policyholders may expect that $72.00 of every $100.00 in premium will be returned as benefits to Policyholders over the life of the contract.

Forethought Life Insurance Company Administrative Office P.O. Box 14659, Clearwater, FL 33766-4659 (877) 492-5870

MONTHLY PREMIUMS

ZIP CODES: 551, 554

NON-TOBACCO - MONTHLY RATES		TOBACCO - MONTHLY RATES	
Basic - Policy Form MSBA10-01 MN		**Basic - Policy Form MSBA10-01 MN**	
ALL AGES	$150.74	ALL AGES	$173.26
Optional Riders		Optional Riders	
Medicare Part A Deductible Rider MS2010A-01-MN	$30.25	Medicare Part A Deductible Rider MS2010A-01-MN	$34.78
Medicare Part B Deductible Rider MS2010B-01-MN	$13.50	Medicare Part B Deductible Rider MS2010B-01-MN	$13.50
Preventive Medical Care Benefits Rider MS2010PC-01-MN	$7.07	Preventive Medical Care Benefits Rider MS2010PC-01-MN	$8.13
Medicare Part B Excess Charges Rider MS2010BX-01-MN	$4.90	Medicare Part B Excess Charges Rider MS2010BX-01-MN	$5.63
Extended Basic - Policy Form MSXT10-01-MN		**Extended Basic - Policy Form MSXT10-01-MN**	
ALL AGES	$421.30	ALL AGES	$484.26
$20 and $50 Copayment Plan - Policy Form MSCO10-01-MN		**$20 and $50 Copayment Plan - Policy Form MSCO10-01-MN**	
ALL AGES	$152.56	ALL AGES	$175.36

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively.

The policy provides an anticipated loss ratio of 72%. This means that, on the average, Policyholders may expect that $72.00 of every $100.00 in premium will be returned as benefits to Policyholders over the life of the contract.

Disclosures
Use this outline to compare benefits and premiums among policies.

Read Your Policy Very Carefully
This is only an outline describing your Policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and Forethought Life Insurance Company.

Right To Return Policy
If you find that you are not satisfied with your policy, you may return it to Forethought Life Insurance Company at our administrative office, P.O. Box 14659, Clearwater, FL 33766-4659. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments, within 10 days.

Policy Replacement
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice
This policy may not fully cover all of your medical costs. Neither Forethought Life Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare and You" for more details.

Complete Answers Are Very Important
Review the application carefully before you sign it. Be certain that all information has been properly recorded.

THE POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THE POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

We will not pay for services for which a charge is normally not made when there is no insurance. In addition, no benefits are payable for expense incurred before the coverage effective date.

Limitation On Out-of-Pocket Expense
When your out-of-pocket expense equals $1,000.00 in a calendar year, we will pay 100% of additional covered expense you incur during the remainder of such calendar year we will pay 100% of additional covered expense you incur during the remainder of such calendar year for the Extended Basic Policy, Form MSXT10-01-MN.

BASIC PLAN - MSBA10-01-MN
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN MSBA10-01-MN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,156	$0	$1,156 (Part A Deductible)
		$1156 with Optional Benefit Rider MS2010A-01-MN	$0
61st thru 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $578 a day	$578 a day	$0
• Beyond the additional 150 days	$0	100% of Medicare Eligible Expenses	$0
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 $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

BASIC PLAN - MSBA10-01-MN
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN MSBA10-01-MN 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 $140 of Medicare-approved amounts*	$0	$0	$140 (Part B Deductible)
		$140 with Optional Benefit Rider MS2010B-01-MN	$0
Remainder of Medicare Approved amounts	80%	20% **	$0
Part B Excess Charges (Above Medicare Approved amounts)	$0	$0	All costs
		$140 with Optional Benefit Rider MS2010B-01-MN	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $140 of Medicare Approved amounts*	$0	$0	$140 (Part B Deductible)
		$140 with Optional Benefit Rider MS2010B-01-MN	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* Once You have been billed $140 of Medicare Approved amounts for covered services, Your Part B Deductible will have been met for the calendar year.

** Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

BASIC PLAN - MSBA10-01-MN
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN MSBA10-01-MN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $140 of Medicare Approved amounts*	$0	$0 $140 with Optional Benefit Rider MS2010B-01-MN	$140(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 services beginning during travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.			$120
• First $120 each calendar year	$0	$0 $120 with Optional Benefit Rider MS2010PC-01-MN	$0
• Additional Changes	$0	$0 $0 with Optional Benefit Rider MS2010BX-01-MN	All Costs All Costs

EXTENDED BASIC PLAN - MSXT10-01-MN
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN MSXT10-01-MN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1156	$1156 (Part A Deductible)	$0
61st thru 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $578 a day	$578 a day	$0
• Beyond the additional 150 days	$0	100% of Medicare Eligible Expenses	$0
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 $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	80% of covered expenses up to 120 days per year	Expenses not paid by policy
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and respite care	Medicare copayment/coinsurance	$0

EXTENDED BASIC PLAN - MSXT10-01-MN
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN MSXT10-01-MN 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 $140 of Medicare Approved amounts*	$0	$140 (Part B Deductible)	$0
Remainder of Medicare Approved amounts	80%	20%**	$0
Part B Excess Charges (Above Medicare Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $140 of Medicare Approved amounts*	$0	$140 (Part B Deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* Once You have been billed $140 of Medicare Approved amounts for covered services, Your Part B Deductible will have been met for the calendar year.

** Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

EXTENDED BASIC PLAN - MSXT10-01-MN
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONTINUED)
PARTS A & B

* Once You have been billed $140 of Medicare Approved amounts for covered services, Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN MSXT10-01-MN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $140 of Medicare Approved amounts*	$0	$140 (Part B Deducticble)	$0
Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary services beginning during travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Annual physical and preventive tests such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare.			
• First $120 each calendar year	$0	$120	$0
• Additional Charges	$0	$0	All Costs

$20 AND $50 COPAYMENT - MSCO10-01-MN
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN MSCO10-01-MN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1156	$1156 (Part A Deducticble)	$0
61st thru 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $578 a day	$578 a day	$0
• Beyond the additional 150 days	$0	100% of Medicare Eligible Expenses	$0
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 $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and respite care	Medicare copayment/ coinsurance	$0

$20 AND $50 COPAYMENT - MSC010-01-MN
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN MSC010-01-MN 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 $140 of Medicare Approved amounts*	$0	$0	$140 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency room visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency room visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All Costs	$0
Next $140 of Medicare Approved amounts*	$0	$0	$140 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* Once You have been billed $140 of Medicare Approved amounts for covered services, Your Part B Deductible will have been met for the calendar year.

$20 AND $50 COPAYMENT - MSC010-01-MN
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONTINUED)
PARTS A & B

* Once You have been billed $140 of Medicare Approved amounts for covered services, Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN MSCO10-01-MN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $140 of Medicare Approved amounts*	$0	$0	$140 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary services beginning during travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE SERVICES AND DIAGNOSTIC PROCEDURES FOR CANCER SCREENING – NOT COVERED BY MEDICARE	$0	100% of cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening after payment of Medicare Part B deductible	Expenses not paid by Medicare or the policy

The charts above summarizing the Medicare benefits only briefly describe the benefits. The Health Care Financing Administration or its Medicare publication should be consulted for further details and limitations.

ADDITIONAL BENEFITS Apply to all Plans

1. Alcoholism and Chemical Dependency Treatment Benefit. We will pay the Usual and Customary Charge for the treatment of alcoholism and chemical dependency on the same basis as any other Sickness or Injury when treatment is provided for: (a) outpatient alcoholism and chemical ependency services that must not place a greater financial burden on you, or be more restrictive than those requirements and limitations for outpatient medical services; and (b) inpatient hospital and residential alcoholism and chemical dependency services that must not place a greater financial burden on you, or be more restrictive than those requirements and limitations for inpatient hospital medical services. Benefits are not payable for that portion of expense paid by Medicare or paid under any other part of the policy.
2. Scalp Hair Prosthesis. We will pay the expense incurred on the same basis as any other Sickness or Injury and as if Medicare paid benefits for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata. Only the first $350.00 of expense incurred in a calendar year will be considered as expense under this part of your policy. Amounts in excess of the Usual and Customary Charge are not considered expense. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of this policy.
3. Routine Screening Procedures for Cancer. We will pay the expense incurred that is not paid by Medicare or paid under any other part of your policy for routine screening procedures for cancer, including colorectal screening, mammogram and Pap smear.
4. Temporomandibular Joint Disorder and Craniomandibular Disorder. Benefits are payable for the surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a physician or dentist. Benefits are not payable under this part of your policy for any expense payable under another part of the policy.
5. Reconstructive Surgery. Benefits are payable for reconstructive surgery on the same basis as that for any other surgery if the reconstructive surgery is incidental to or follows surgery resulting from Injury, Sickness or other disease of the involved part. Benefits are not payable under this part of your policy for any expense payable under another part of the policy.
6. Outpatient Medical and Surgical Center Services Benefit. Benefits are payable for surgical center services for health care treatment or service rendered by a freestanding ambulatory surgical center or facilities offering ambulatory medical service 24 hours a day, 7 days a week, which are not part of a hospital, but have been reviewed and approved by the state commissioner of commerce to provide treatment or service on the same basis as coverage provided for the same health care treatment or service rendered by a hospital. Benefits are not payable under this part of your policy for an expense payable under another part of the policy.
7. Immunization Benefits. We will pay the expense incurred for an immunization received by you. Benefits are not payable for that portion of expense paid by Medicare or paid under any other part of the policy.
8. Phenylketonuria Treatment. Benefits are payable for special dietary treatment for phenylketonuria when recommended by a physician.
9. Diabetes Equipment and Supplies. We will pay the Usual and Customary Charge for expense incurred for all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, not otherwise covered by Medicare or Part D of the Medicare Program. Coverage must include persons with gestational, type I or type II diabetes. Benefits will be limited to 80% of the Usual and Customary Charge not covered by Medicare or Part D of the Medicare Program.
10. Routine Prostate Cancer Screening. We will pay the expense incurred for prostate cancer screening. Benefits are limited to at least one screening per year for any insured male 50 years of age or older, and at least one screening per year for any insured male 40 years of age or older who is symptomatic.
11. Outpatient Mental Health Coverage. We will pay the allowable amount not paid by Medicare, less the Part B Deductible if applicable.
12. Physical and Occupational Therapy Services. We will pay the allowable amount not paid by Medicare, less the Part B Deductible if applicable.
13. Treatment of Lyme Disease. We will pay benefits for diagnosed Lyme Disease as any other medical service. Benefits are not payable for that portion of expense paid by Medicare or paid under any other part of the policy.

ADDITIONAL BENEFITS UNDER EXTENDED BASIC PLAN – MSXT10-01-MN

We will pay 80% of the Usual and Customary Charges for the following articles and services prescribed by a physician which are not paid by Medicare or payable under any other provision of your policy.

1. Hospital services.
2. Professional services for the diagnosis or treatment of Injuries, Sickness or conditions when such services are given by a physician or are under a physician's direction. Outpatient mental and dental services are not covered.
3. Services of a nursing home for not more than 120 days each year. Such services must qualify as reimbursable under Medicare.
4. Services of a home health agency. Such services must qualify as reimbursable under Medicare.
5. Use of radium or other radioactive materials.
6. Oxygen.
7. Anesthetics.
8. Prosthetic devises other than dental.
9. Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aid
10. Diagnostic X-rays and lab tests.
11. Oral surgery for: (a) partially or completely unerupted impacted teeth, (b) a tooth root without the extraction of the entire root, or (c) the gums or tissues of the mouth when not performed in connection with the extraction or repair of teeth.
12. Services of a physical therapist.
13. Professional ambulance for service to the nearest facility qualified to treat the condition, or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.
14. Well-baby care.
15. A second opinion from a Physician on all surgical procedures expected to cost at least $500.00. Cost includes Physician, laboratory and Hospital fees. Not included is the repetition of any diagnostic test.
16. Services of an occupational therapist.

The above Additional Benefits are not payable for: (a) Injuries or Sickness for which any benefits are provided for by workers' compensation or employer's liability laws, (b) cosmetic surgery, except for repair of an Injury or a birth defect, (c) care which is primarily for custodial or for domiciliary purposes which would not qualify as eligible services under Medicare, (d) any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room unless the private room is prescribed as medically necessary by a physician, or (e) any charges for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

LIMITATIONS

The policy DOES NOT cover the following:

a) Private Duty Nursing.
b) Custodial nursing home care costs.
c) Intermediate nursing home care costs.
d) Physician's charges above Medicare's approved charges, except as explained in the Additional Benefits section of this outline.

OPTIONAL COVERAGE AVAILABLE FOR BASIC PLAN – MSBA10-01-MN (check if applied for)

❑ **MS2010A-01-MN – Medicare Part A Deductible Rider**

When you are hospital confined for a covered condition, we will pay the Medicare Part A Deductible of $1,156 that you incur.

❑ **MS2010BX-01-MN – Medicare Part B Excess Charges Rider**

If you incur expenses for services or supplies that are eligible under Medicare Part B, we will pay that portion of the Usual and Customary Charge which:

a) Is in excess of the Medicare Part B approved charge and
b) You are required to pay.

❑ **MS2010B-01-MN – Medicare Part B Deductible Rider**

When you incur expense that is applied to the Medicare Part B Deductible and Medicare does not pay the deductible, we will pay the entire Medicare Part B annual deductible.

❑ **MS2010PC-01-MN – Preventive Medical Care Benefits Rider**

We will pay the Medicare-approved amount for each of the following preventive health services, as if Medicare were to cover the service, as identified in the American Medical Association's current procedural terminology (AMA CPT) codes to a maximum of $120.00 annually under this benefit:

a) An annually clinical preventive medical history and physical exam that may include tests and services from item (b) below and patient education to address preventive health care measures;
b) Any one or combination of the following preventive screening tests or preventive services, as often as medically necessary: fecal occult blood test and/or digital rectal exam; dipstick urinalysis for hematuria, bacteriurua, and proteinuria; pure tone (air only) hearing screening test, ordered or administered by a physician; serum cholesterol every five years; thyroid function test; diabetes screening; and/or any other tests or preventive measures determined appropriate by the attending physician.

Benefits for Preventive Health Services will not duplicate any payment for a procedure that is already covered by Medicare.

Agent checklist for completing the Medicare Supplement Application

FORE THOUGHT®

This packet contains the following forms needed to complete an Application For Medicare Supplement Insurance. Please tear out the **application** and all pages marked **"RETURN TO COMPANY"** and leave the remaining pages with the applicant(s). Please review the following information carefully and complete all needed forms:

- ❑ Application For Medicare Supplement Insurance (Form MSAP1000-01 or MSAPC1000-01)
  - Medicare Supplement – If the applicant(s) is applying during Open Enrollment or a Guaranteed Issue period, Section 4 is not required to be completed
  - Section 5 should be completed only if the applicant(s) would like his/her payments to be deducted automatically from his/her checking/savings account. This option applies only if premiums are paid monthly
- ❑ Agent Certification (Form AGTCRT10-01) – This form must be signed by the agent and by the applicant(s).
- ❑ Calculate your premium – This form is used in coordination with the Outline of Coverage, to calculate the correct (Medicare Supplement premium). This form must be returned with the application.
- ❑ Fax Transmittal – Follow the instructions on this form only if the applicant(s) elects to pay premiums using ACH and you are submitting the underwriting documents via fax instead of regular mail.
- ❑ Authorization to Release Confidential Medical Information (Form MS-HIPAA10-01) – Must be completed **only** if applying outside Open Enrollment or a Guaranteed Issue period for Medicare Supplement. If both spouses are applying for coverage on the same application, then both must sign the form.
- ❑ Notice to Applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage (Form MS-RN10-01) – This form must be completed if replacement of an existing Medicare Supplement policy is involved. One signed copy must be returned to the Administrative Office and the other signed copy must be left with the applicant(s).
- ❑ Investigative Consumer Report Notice to Applicant, MIB, Inc. Disclosure Notice and Medicare Supplement/Select Initial Premium Receipt (MSREC-02) – The Initial/Premium Receipt must be left with the applicant(s) and the full modal premium is required with all applications.

Please note, you are also required to provide the applicant(s) with the following items:

- ❑ Guide to Health Insurance for People with Medicare
- ❑ Outline of Coverage (Form MSOC10-01)

Premiums

Utilize the Outline of Coverage to determine Medicare Supplement premiums.

- Determine ZIP code where the client resides and find the correct rate page for that ZIP code
- Determine if tobacco or non-tobacco use
- Determine Plan
- Determine riders to be included, if applicable
- Use the Calculate your premium form to calculate the monthly premium and adjust it for different modes
- A voided check needs to be submitted with the Application for EFT

Mailing Address
Forethought Life Insurance Company
Administrative office
P.O. Box 14659
Clearwater, FL 33766-4659

Overnight/Express Address
Forethought Life Insurance Company
Administrative office
2650 McCormick Drive
Clearwater, FL 33759

FAX Number for New Business - EFT Applications 1-855-808-0944

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FORE THOUGHT®

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

Forethought Life Insurance Company
One Forethought Center
Batesville, Indiana 47006

Administrative Office:
P. O. Box 14659
Clearwater, FL 33766-4659

MEDICARE SUPPLEMENT PLAN INFORMATION (To be completed by Producer)

NOTE: For ALL sections, complete the Applicant B information ONLY if Applicant B is to be insured.

APPLICANT	
☐ Basic Plan ☐ Part A Deductible Rider ☐ Preventive Rider ☐ Part B Excess Rider ☐ Part B Deductible Rider	☐ Extended Basic Plan ☐ $20 and $50 Copayment - Part B Coverage Plan
Requested Effective Date	Mail Policy To ☐ Insured ☐ Agent
Initial Premium Collected $	Renewal Premium $
Renewal Premium Mode ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT	
APPLICANT B	
☐ Basic Plan ☐ Part A Deductible Rider ☐ Preventive Rider ☐ Part B Excess Rider ☐ Part B Deductible Rider	☐ Extended Basic Plan ☐ $20 and $50 Copayment - Part B Coverage Plan
Requested Effective Date	Mail Policy To ☐ Insured ☐ Agent
Initial Premium Collected $	Renewal Premium $
Renewal Premium Mode ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT	

SECTION 1 – PLEASE ANSWER ALL QUESTIONS COMPLETELY.

APPLICANT			
Last Name	First	M.I.	
Mailing Address			
Residential Address *(if different from Mailing Address)*			
City	State	Zip	
Age / Date of Birth	State of Birth	☐ Male ☐ Female	
Home Phone # ( ) -	E-Mail Address		
Social Security Number	Height	Weight	
Medicare Health Insurance Card Number (if known)			
Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No			
APPLICANT B			
Last Name	First	M.I.	
Mailing Address			
Residential Address *(if different from Mailing Address)*			
City	State	Zip	
Age / Date of Birth	State of Birth	☐ Male ☐ Female	
Home Phone # ( ) -	E-Mail Address		
Social Security Number	Height	Weight	
Medicare Health Insurance Card Number (if known)			
Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No			

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SECTION 2 –PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

	APPLICANT	APPLICANT B
1. Have you received a copy of the Guide to Health Insurance for **People with Medicare** and the **Outline of Coverage**?	☐ Yes ☐ No	☐ Yes ☐ No
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A: If "YES," what is your Part A effective date? _____/_____ (Applicant / Applicant B) If "NO," what is your eligibility date? _____/_____ (Applicant / Applicant B)	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you covered under Medicare Part B? If "YES," what is your Part B effective date? _____/_____ (Applicant / Applicant B) If "NO," indicate date you plan to enroll. _____/_____ (Applicant / Applicant B)	☐ Yes ☐ No	☐ Yes ☐ No
3. Did you turn age 65 in the last six months?	☐ Yes ☐ No	☐ Yes ☐ No
4. Did you enroll in Medicare Part B in the last six months?	☐ Yes ☐ No	☐ Yes ☐ No
5. If "YES," indicate your effective date. _____/_____ (Applicant / Applicant B)		

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement Insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed accepted in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.**

SECTION 3 – FOR YOUR PROTECTION, THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS REQUESTS THAT WE ASK THE FOLLOWING QUESTIONS ABOUT INSURANCE POLICIES OR CERTIFICATES YOU MAY HAVE.

To the Best of Your Knowledge:	**APPLICANT**	**APPLICANT B**
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.)	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you have another Medicare Supplement Insurance policy or certificate in force (Select or Standard)? (a) If "YES," please complete the following:	☐ Yes ☐ No	☐ Yes ☐ No

APPLICANT	
Name of Company	Policy/Certificate Number
Plan	Issue Date
APPLICANT B	
Name of Company	Policy/Certificate Number
Plan	Issue Date

(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy?	☐ Yes ☐ No	☐ Yes ☐ No
(c) If "YES," indicate termination date. _____/_____ (Applicant / Applicant B)		
(d) If "YES," have you received a copy of the **replacement notice**?	☐ Yes ☐ No	☐ Yes ☐ No
If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.		
3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START_____ END _____ / START_____ END _____ (Applicant / Applicant B)		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No

(b) If "YES," have you received a copy of the **replacement notice?** (c) Reason for termination/disenrollment? _____/_____ **Applicant** **Applicant B** (d) Planned date of termination/disenrollment? _____/_____ **Applicant** **Applicant B**	☐ Yes ☐ No	☐ Yes ☐ No
(e) Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
(f) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
(g) Is your former Medicare supplement or Medicare Select policy/certificate still available?	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) (a) If "YES," with what company and what kind of policy/certificate?(list below)	☐ Yes ☐ No	☐ Yes ☐ No

APPLICANT	
Name of Company	Kind of Policy/Certificate
APPLICANT B	
Name of Company	Kind of Policy/Certificate

(b) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank. START_____ END _____ / START_____ END _____
Applicant **Applicant B**

(c) Reason for termination/disenrollment?
_____/_____
Applicant **Applicant B**

(d) Planned date of termination/disenrollment?
_____/_____
Applicant **Applicant B**

5. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) If "YES,"	☐ Yes ☐ No	☐ Yes ☐ No
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	☐ Yes ☐ No	☐ Yes ☐ No
6. Producers shall list any other health insurance policies/certificates they have sold to the applicant. (a) List policies/certificates sold which are still in force.		

APPLICANT *(attach a separate sheet if needed)*	
Name of Company	Policy/Certificate #
Description of Benefits	Effective Date of Coverage
List policies/certificates sold in the past five (5) years which are no longer in force:	
Name of Company	Policy/Certificate #
Description of Benefits	Effective Date of Coverage
APPLICANT B *(attach a separate sheet if needed)*	
Name of Company	Policy/Certificate #
Description of Benefits	Effective Date of Coverage
List policies/certificates sold in the past five (5) years which are no longer in force:	
Name of Company	Policy/Certificate #
Description of Benefits	Effective Date of Coverage

If applying during Open Enrollment or a Guaranteed Issue period, SKIP SECTION 4 and GO TO SECTION 5.

SECTION 4

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. Make sure all questions are answered by each applicant. If either you or Applicant B answer "YES" to any of the following questions 1-14, that person is not eligible for coverage.

To the Best of Your Knowledge:	APPLICANT	APPLICANT B
1. Are you currently hospitalized or confined to a nursing facility; or are you bedridden or confined to a wheelchair?	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis?	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No	☐ Yes ☐ No
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? If you do **not** have diabetes, this question should be answered "NO".	☐ Yes ☐ No	☐ Yes ☐ No
7. Do you have diabetes that has ever required more than 50 units of insulin daily?	☐ Yes ☐ No	☐ Yes ☐ No
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?	☐ Yes ☐ No	☐ Yes ☐ No
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?	☐ Yes ☐ No	☐ Yes ☐ No
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	☐ Yes ☐ No	☐ Yes ☐ No
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	☐ Yes ☐ No	☐ Yes ☐ No
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	☐ Yes ☐ No	☐ Yes ☐ No
13. Have you been hospital confined three or more times in the last two years?	☐ Yes ☐ No	☐ Yes ☐ No
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	☐ Yes ☐ No	☐ Yes ☐ No
15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please list the drug and the condition in the following table.	☐ Yes ☐ No	☐ Yes ☐ No

APPLICANT *(attach a separate sheet if needed)*	
Medication Name (pharmacy label)	Date **Originally** Prescribed
Frequency and Dosage	Diagnosis/Condition

APPLICANT B *(attach a separate sheet if needed)*	
Medication Name (pharmacy label)	Date **Originally** Prescribed
Frequency and Dosage	Diagnosis/Condition

SECTION 5 - BILLING INFORMATION

A. ELECTRONIC FUNDS TRANSFER (EFT)

☐ Checking ☐ Savings	Account # ABA Routing/Transit Number

☐ Standard Date *(approximately 30 days from the issue date of coverage)*
☐ Custom Date_____ (Select 1-28)

When processing is not complete prior to the custom date selected, two (2) premium payments may be withdrawn the following month to keep your policy current. To prevent this from happening, you may prefer to include an additional premium payment.

Name and Telephone Number of Financial Institution	Social Security Number of Account Holder

B. INITIAL CREDIT CARD PAYMENT – ***(Initial Premium can be made on credit card; this is not available for Renewal Premiums)***

Account #_____ Exp. Date_____
Please print clearly

NOT AVAILABLE

Cardholder Name

C. AUTOMATIC PAYMENT AUTHORIZATION – ***(Must be completed for EFT)***

I authorize Forethought Life Insurance Company ("Forethought") to charge/deduct my insurance premium from my account. This authorization is to remain in effect until I revoke my automatic monthly premium payment by notifying Forethought.

Payor's Signature *(As it appears on the bank account)*	Date

SECTION 6 – SIGNATURES – PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT IF PURCHASING MEDICARE SUPPLEMENT INSURANCE COVERAGE

- 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 multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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).

I understand that Forethought may obtain an investigative consumer report on me and a telephone interview may be necessary to verify or supplement information given on this application. I understand that it is my right to request to be interviewed and that I may request a copy of the report if no personal interview is conducted. A photocopy of this form will be as valid as the original. This Authorization and Acknowledgment will be valid for 24 months after it is signed. I understand that no agent has the right to waive any of Forethought's rights or requirements, or to make or alter any contract or policy. I agree that my statements and answers to the questions in this application are complete and true to the best of my knowledge and belief and are the basis for issuing a policy.

By this application I am applying to Forethought for a Medicare supplement insurance policy. I understand that, (a) upon acceptance of the completed application, each applicant will receive a separate policy; (b) my policy benefits can start no earlier than my Medicare effective date(s), my first month's premium has been received and/or processed and my application has been approved by Forethought.

I understand that any person who, knowingly and with intent to defraud any insurance company or other persons, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signed this _____ day of _____, _____ in _____, _____. _____
Day Month Year City State APPLICANT SIGNATURE

Signed this _____ day of _____, _____ in _____, _____. _____
Day Month Year City State APPLICANT B SIGNATURE (if applicable)

AGENT ONLY SECTION – PREMIUM MUST ACCOMPANY APPLICATION

I certify that during an interview with the applicant(s) I have truly and accurately recorded in the application the information supplied by the applicant(s).

_____

Producer's Name (PRINT) Producer Number Telephone Number Producer's Signature

SECTION FOR ADDITIONAL COMMENTS

APPLICANT - (please attach a separate sheet if needed)
APPLICANT B - (please attach a separate sheet if needed)

Agent Certification

FORETHOUGHT LIFE INSURANCE COMPANY
Administrative Office P.O. Box 14659, Clearwater, FL 33766-4659 1-877-492-5870

FORE THOUGHT®

I the undersigned insurance agent certify;

THAT, I have taken an application for:

Primary insured:
Medicare Supplement Standard

❑ **Basic Plan**
Riders:
- ❑ Medicare Part A Deductible
- ❑ Medicare Part B Deductible
- ❑ Preventive Medical Care Benefits
- ❑ Medicare Part B Excess Charges

❑ **Extended Basic Plan**

❑ **$20 and $50 Copayment Plan**

Applicant B:
Medicare Supplement Standard

❑ **Basic Plan**
Riders:
- ❑ Medicare Part A Deductible
- ❑ Medicare Part B Deductible
- ❑ Preventive Medical Care Benefits
- ❑ Medicare Part B Excess Charges

❑ **Extended Basic Plan**

❑ **$20 and $50 Copayment Plan**

Offered by FORETHOUGHT LIFE INSURANCE COMPANY,

to _____
(Applicant(s)),

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

❑ Check ❑ ACH (Check appropriate method of payment)

THAT, I have clearly explained any benefits of this plan 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 Centers for Medicare and Medicaid Services in connection with this insurance policy being applied for.

_____
Date

_____
Signature of agent

I, the undersigned applicant, understand that I will receive a copy of this form when my policy is issued and delivered to me.

_____
Name of agency

_____
Signature of applicant

_____
Address of agent / Agency

_____
Signature of spouse, if applying

_____
Phone number

AGTCRT10-01-MN

RETURN TO COMPANY

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Forethought Life Insurance Company
PO Box 14659
Clearwater, FL 33766-4659

Authorization to Release Confidential Medical Information

Records and information obtained will be disclosed to Forethought Life Insurance Company so that it can: 1) evaluate my application for insurance; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) and administer coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, the MIB, Inc., the Veterans Administration, other insurance companies, or anyone else to release any and all records and information to be exchanged between Forethought Life Insurance Company and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and it assigns as necessary to fulfill the purpose of this disclosure.

I hereby authorize you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to testing, treatmet, or advice for the following: alcohol abuse, drug abuse, psychiatric and psychological disorders, heart disease, mental disease, genetic disorders, pharmacy prescriptions, HIV or AIDS, sexually transmitted diseases, hepatitis, and Sickle Cell Anemia.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. I understand Forethought Life Insurance Company may report information to MIB, Inc. or to other insurance companies to which I have or may apply. I understand this Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Forethought Life Insurance Company at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Forethought Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

Name of Proposed Insured (please print)	Name of Proposed Insured B (please print)
Signature of Proposed Insured	Signature of Proposed Insured B
Date	Date

RETURN TO COMPANY

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Calculate your premium

Forethought® Medicare Supplement

Medicare Supplement Plan _____

Before you begin: *If you're not in your open enrollment or guarantee issue period, please see chart below to determine your eligibility for coverage.*

Steps	**Example** Rates displayed are used for calculation purposes only.	Applicant's premium	Applicant B's premium
Premium Write in your Medicare Supplement Plan's premium and any applicable rider premiums from the Outline of Coverage table.	$114.27 + $10.50 + $3.75= $128.52		
Payment Options To determine other payment schedules, multiply your monthly premium by: 3 to pay four times a year (quarterly) 6 to pay twice a year (semi-annually) 12 to pay once a year (annually)	$128.52 Monthly payment $385.56 Quarterly payment $771.12 Semi-annual payment $1,542.24 Annual payment		

Height and weight chart

To determine whether you may purchase coverage, locate your height, then weight in the chart below. If your weight is not in the Standard column, we're sorry, you're not eligible for coverage at this time. If your weight is located in the Standard column, you may proceed in completing the application.

FORETHOUGHT® MEDICARE SUPPLEMENT

	Decline	Standard	Decline
Height	Weight	Weight	Weight
4′ 2″	< 54	54 – 145	146 +
4′ 3″	< 56	56 – 151	152 +
4′ 4″	< 58	58 – 157	158 +
4′ 5″	< 60	60 – 163	164 +
4′ 6″	< 63	63 – 170	171 +
4′ 7″	< 65	65 – 176	177 +
4′ 8″	< 67	67 – 182	183 +
4′ 9″	< 70	70 – 189	190 +
4′ 10″	< 72	72 – 196	197 +
4′ 11″	< 75	75 – 202	203 +
5′ 0″	< 77	77 – 209	210 +
5′ 1″	< 80	80 – 216	217 +
5′ 2″	< 83	83 – 224	225 +
5′ 3″	< 85	85 – 231	232 +
5′ 4″	< 88	88 – 238	239 +
5′ 5″	< 91	91 – 246	247 +
5′ 6″	< 93	93 – 254	255 +
5′ 7″	< 96	96 – 261	262 +
5′ 8″	< 99	99 – 269	270 +

	Decline	Standard	Decline
Height	Weight	Weight	Weight
5′ 9″	< 102	102 – 277	278 +
5′ 10″	< 105	105 – 285	286 +
5′ 11″	< 108	108 – 293	294 +
6′ 0″	< 111	111 – 302	303 +
6′ 1″	< 114	114 – 310	311 +
6′ 2″	< 117	117 – 319	320 +
6′ 3″	< 121	121 – 328	329 +
6′ 4″	< 124	124 – 336	337 +
6′ 5″	< 127	127 – 345	346 +
6′ 6″	< 130	130 – 354	355 +
6′ 7″	< 134	134 – 363	364 +
6′ 8″	< 137	137 – 373	374 +
6′ 9″	< 140	140 – 382	383 +
6′ 10″	< 144	144 – 392	393 +
6′ 11″	< 147	147 – 401	402 +
7′ 0″	< 151	151 – 411	412 +
7′ 1″	< 155	155 – 421	422 +
7′ 2″	< 158	158 – 431	432 +
7′ 3″	< 162	162 – 441	442 +
7′ 4″	< 166	166 – 451	452 +

COMPLETE AND RETURN WITH APPLICATION

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Forethought Life Insurance Company
Administrative Office
PO Box 14659 • Clearwater, FL 33766-4659

Notice to Applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Forethought Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance 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. If, after due consideration and acceptance by the replacing insurer, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT
I HAVE REVIEWED YOUR CURRENT MEDICAL OR HEALTH INSURANCE COVERAGE. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s)

- ❑ Additional benefits.
- ❑ No change in benefits, but lower premiums.
- ❑ Fewer benefits and lower premiums.
- ❑ My plan has outpatient drug coverage and I am enrolling in Part D.
- ❑ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.
- ❑ Other, (please specify) _____.

1. State laws provide that your replacement policy or certificate 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.

2. 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 any company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____ _____
Signature of Agent, Broker, or other Representative | PRINTED Name and Address of Issuer, Agent, or Broker

_____ _____
Applicant's Signature | Signature of Applicant B, if applying

_____
Date

MS-RN10-01

RETURN TO COMPANY

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Forethought Life Insurance Company
Administrative Office
PO Box 14659 • Clearwater, FL 33766-4659

Notice to Applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Forethought Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance 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. If, after due consideration and acceptance by the replacing insurer, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT
I HAVE REVIEWED YOUR CURRENT MEDICAL OR HEALTH INSURANCE COVERAGE. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s)

- ❑ Additional benefits.
- ❑ No change in benefits, but lower premiums.
- ❑ Fewer benefits and lower premiums.
- ❑ My plan has outpatient drug coverage and I am enrolling in Part D.
- ❑ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.
- ❑ Other, (please specify) _____.

1. State laws provide that your replacement policy or certificate 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.

2. 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 any company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____ _____
Signature of Agent, Broker, or other Representative | PRINTED Name and Address of Issuer, Agent, or Broker

_____ _____
Applicant's Signature | Signature of Applicant B, if applying

_____
Date

MS-RN10-01

LEAVE WITH APPLICANT

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Forethought Life Insurance Company
PO Box 14659
Clearwater, FL 33766-4659

INVESTIGATIVE CONSUMER REPORT NOTICE TO APPLICANT

Federal law requires that notice of investigation be given to persons applying for insurance. In making this application for insurance to Forethought Life Insurance Company (the Company), it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living (the term "mode of living" does not relate directly or indirectly to the sexual orientation of any proposed insured). You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon proper identification, you have the right to inspect and/or receive a copy of the report from the consumer reporting agency. You have the right to make a written request to the Company within a reasonable period of time to receive additional detailed information about the nature and scope of the investigation. Write to: Underwriting Department, Forethought Life Insurance Company, P.O. Box 14659, Clearwater, Florida, 33766-4659.

MIB, INC. DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Forethought Life Insurance Company (the Company) or it's reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The Company or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

MEDICARE SUPPLEMENT / SELECT INITIAL PREMIUM RECEIPT

MAKE CHECK PAYABLE TO: FORETHOUGHT LIFE INSURANCE COMPANY

Received from _____(Proposed Insured) an application for a Medicare Supplement / Medicare Select Policy with Forethought Life Insurance Company (the Company), and $ _____ for the initial premium. In the event the application is not accepted by the Company, the above amount will be refunded. No obligation is incurred by the Company unless said application is approved by the Company at its Administrative Office and a policy is issued.

_____	_____	_____
Agent's Name (please print)	Agent's Signature	Date

LEAVE WITH APPLICANT

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Forethought Life Insurance Company

Consumers choosing to have initial premiums paid through ACH (Automated Clearing House) for Medicare Supplement Applications may have their initial premium automatically deducted from their checking or savings account through the Electronic Funds Transfer (EFT) process. When they do, you may fax the application and required forms instead of mailing them.

Follow these easy steps to submit Medicare Supplement Apps using ACH for the initial premium:

STEP 1 – COMPLETE THE AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER SECTION ON THE APPLICATION.

Applicants wishing to pay electronically will need to complete the appropriate Medicare Supplement Authorization for Electronic Funds Transfer section on the Application.

STEP 2 – FAX THE FOLLOWING ITEMS TO THE DEDICATED LINE FOR ACH PAYMENTS AT 1-855-808-0944

1) ACH fax transmittal cover sheet on the back of this form

2) Medicare Supplement Application and other required forms including authorization for EFT

3) Voided check for EFT

If you fax the application, do not mail it as processing errors occur and additional charges could result in the duplication.

For producer use only. Not for use with the general public.

THINKING AHEAD℠ FORETHOUGHT®

MSFAX01-02

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Forethought Life Insurance Company

FAX TRANSMITTAL

FOR USE WITH EFT MONTHLY PREMIUM APPLICATIONS ONLY

1-855-808-0944

Use this fax number only for applications and new business documents. Applications faxed to any other number can cause delays in processing your business.

Please complete the following information:

Total number of pages being faxed including this cover sheet _____

Producer Name _____

Producer Number or SSN _____

Producer Phone Number _____

Producer Fax Number _____

Comments _____

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This communication and any attachments transmitted with it are confidential and are solely for the use of the addressee. It may contain material that is legally privileged, proprietary or subject to copyright belonging to Forethought Life Insurance Company and its affiliates. It may be subject to protection under federal or state law. If you are not the intended recipient, you are notified that any use of this material is strictly prohibited. If you received this transmission in error, please contact the sender immediately by telephone, at 1-877-492-5870. We will arrange for you to return the original material to us via the US Postal Service and if requested, we will reimburse you for such expense.

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