2010 STANDARD Medicare Supplement/ Life Insurance Plans

Issued by Forethought Life Insurance Company

TEXAS

Forethought Life Insurance Company | Administrative Office PO Box 14659, Clearwater, FL 33766-4659 | 1-877-492-5870

Outline of Medicare Supplement Coverage – Cover Page

Benefit Plans A, C, F, G and N

Benefit Chart of Medicare Supplement Plans sold for effective dates on or after June 1, 2010

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

Basic Benefits:

Hospitalization: Part A co-insurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B co-insurance (generally 20% of Medicare-approved expenses), or co-payment for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B co-insurance or co-payments.

Blood: First three pints of blood each year.

Hospice: Part A co-insurance.

A	B	C	D	F*	G
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance
		Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance
	Part A deductible	Part A deductible	Part A deductible	Part A deductible	Part A deductible
		Part B deductible		Part B deductible	
				Part B excess (100%)	Part B excess (100%)
		Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,000 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance, except up to $20 co-payment for office visit, and up to $50 co-payment for ER
50% skilled nursing facility co-insurance	75% skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance
50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
		Foreign travel emergency	Foreign travel emergency
Out-of-pocket limit $4620; paid at 100% after limit reached	Out-of-pocket limit $2310; paid at 100% after limit reached		

PREMIUM INFORMATION

Your premium will increase each year because of the increase in your attained age. We, Forethought Life Insurance Company, can also raise your premium if (a) we change the premium rates which apply to all policies of this form issued by us and in-force in your state; (b) coverage under Medicare changes; or (c) you move to a different ZIP code location.

DISCLOSURES

Use this Outline to compare benefits and premiums among policies.

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

READ YOUR POLICY VERY CAREFULLY

This is only an Outline, describing your Policy's most important features. The Policy is your insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and 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, PO 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 premiums.

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.

LIMITATIONS AND EXCLUSIONS

Your Medicare Supplement Policy will not contain limitations and exclusions that are more restrictive than the limitations and exclusions contained in Medicare. The limitations and exclusions include:

(a) expense incurred while your Policy is not in force, except as provided in the Extension of Benefits section of the Policy;
(b) hospital or skilled nursing facility confinement charges incurred prior to the effective date of coverage of your Policy;
(c) that portion of any expense incurred which is paid for by Medicare;
(d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs and eye refractions;
(e) services for which a charge is not normally made in the absence of insurance; or
(f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or Certificate.

REFUND OF PREMIUM

This Policy contains a provision providing for a refund or partial refund of premium upon your death or the surrender of the Policy.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new Policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your Policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 754 -760, 762 - 769, 778-781, 783, 785 - 792, 795 - 799, 885

Standard Plans - Nonsmoker

Female					*Attained*	*Male*				
Plan A	Plan C	Plan F	Plan G	Plan N	*Age*	Plan A	Plan C	Plan F	Plan G	Plan N
$189.07	N/A	N/A	N/A	N/A	< 65	$217.43	N/A	N/A	N/A	N/A
$80.46	$106.33	$108.90	$88.28	$78.02	65	$92.52	$122.28	$125.24	$101.53	$89.72
$83.22	$109.84	$112.49	$91.18	$80.56	66	$95.70	$126.31	$129.37	$104.86	$92.64
$86.92	$114.56	$117.33	$95.08	$83.98	67	$99.96	$131.75	$134.93	$109.35	$96.58
$89.77	$118.34	$121.20	$98.22	$86.75	68	$103.24	$136.09	$139.38	$112.95	$99.77
$92.53	$122.23	$125.19	$101.47	$89.66	69	$106.41	$140.57	$143.96	$116.69	$103.10
$95.17	$126.01	$129.06	$104.64	$92.49	70	$109.44	$144.91	$148.41	$120.33	$106.37
$97.66	$129.65	$132.78	$107.69	$95.24	71	$112.31	$149.10	$152.70	$123.85	$109.52
$100.02	$133.15	$136.37	$110.64	$97.89	72	$115.02	$153.13	$156.82	$127.23	$112.57
$102.13	$136.36	$139.65	$113.34	$100.33	73	$117.45	$156.82	$160.60	$130.34	$115.38
$103.97	$139.34	$142.70	$115.86	$102.63	74	$119.57	$160.24	$164.10	$133.24	$118.02
$106.59	$143.43	$146.88	$119.32	$105.76	75	$122.58	$164.94	$168.92	$137.21	$121.63
$110.22	$148.95	$152.53	$123.97	$109.97	76	$126.75	$171.29	$175.41	$142.56	$126.46
$111.64	$151.51	$155.15	$126.16	$111.99	77	$128.39	$174.23	$178.42	$145.08	$128.79
$114.06	$155.41	$159.15	$129.46	$115.01	78	$131.17	$178.72	$183.02	$148.88	$132.26
$115.31	$157.77	$161.56	$131.49	$116.88	79	$132.61	$181.43	$185.79	$151.21	$134.42
$116.57	$160.13	$163.98	$133.52	$118.77	80	$134.06	$184.15	$188.57	$153.54	$136.58
$117.74	$162.43	$166.33	$135.50	$120.61	81	$135.40	$186.80	$191.28	$155.82	$138.71
$119.96	$166.24	$170.23	$138.74	$123.60	82	$137.96	$191.18	$195.76	$159.55	$142.13
$120.95	$168.35	$172.38	$140.56	$125.31	83	$139.09	$193.60	$198.24	$161.65	$144.11
$121.85	$170.42	$174.49	$142.36	$127.01	84	$140.12	$195.98	$200.67	$163.71	$146.06
$123.87	$174.05	$178.21	$145.47	$129.88	85	$142.45	$200.16	$204.95	$167.29	$149.37
$124.69	$176.07	$180.27	$147.23	$131.55	86	$143.40	$202.48	$207.31	$169.31	$151.29
$125.54	$178.16	$182.41	$149.05	$133.29	87	$144.37	$204.88	$209.77	$171.41	$153.28
$126.39	$180.20	$184.50	$150.83	$134.98	88	$145.34	$207.23	$212.17	$173.46	$155.23
$127.24	$182.30	$186.65	$152.67	$136.73	89	$146.33	$209.65	$214.64	$175.57	$157.23
$129.33	$186.18	$190.61	$156.04	$139.85	90	$148.73	$214.11	$219.20	$179.44	$160.83
$130.23	$188.36	$192.84	$157.99	$141.72	91	$149.76	$216.61	$221.76	$181.69	$162.97
$131.16	$190.62	$195.15	$160.03	$143.65	92	$150.83	$219.21	$224.42	$184.03	$165.20
$132.11	$192.94	$197.53	$162.11	$145.64	93	$151.93	$221.89	$227.15	$186.43	$167.48
$133.10	$195.39	$200.02	$164.30	$147.72	94	$153.06	$224.69	$230.02	$188.95	$169.88
$135.33	$199.69	$204.42	$168.06	$151.23	95	$155.63	$229.64	$235.08	$193.27	$173.91
$136.27	$202.14	$206.93	$170.27	$153.34	96	$156.71	$232.47	$237.97	$195.81	$176.34
$137.12	$204.49	$209.32	$172.38	$155.37	97	$157.69	$235.16	$240.72	$198.24	$178.67
$137.96	$206.86	$211.75	$174.53	$157.44	98	$158.65	$237.89	$243.52	$200.71	$181.05
$138.81	$209.31	$214.25	$176.74	$159.56	99	$159.63	$240.71	$246.39	$203.26	$183.50

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

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 754 -760, 762 - 769, 778-781, 783, 785 - 792, 795 - 799, 885

Standard Plans - Smoker

Female					*Attained*	*Male*				
Plan A	Plan C	Plan F	Plan G	Plan N	*Age*	Plan A	Plan C	Plan F	Plan G	Plan N
$217.43	N/A	N/A	N/A	N/A	< 65	$250.05	N/A	N/A	N/A	N/A
$92.52	$122.28	$125.24	$101.53	$89.72	65	$106.40	$140.62	$144.02	$116.76	$103.18
$95.70	$126.31	$129.37	$104.86	$92.64	66	$110.06	$145.26	$148.77	$120.58	$106.54
$99.96	$131.75	$134.93	$109.35	$96.58	67	$114.95	$151.51	$155.17	$125.75	$111.07
$103.24	$136.09	$139.38	$112.95	$99.77	68	$118.72	$156.51	$160.29	$129.90	$114.73
$106.41	$140.57	$143.96	$116.69	$103.10	69	$122.38	$161.65	$165.56	$134.20	$118.57
$109.44	$144.91	$148.41	$120.33	$106.37	70	$125.86	$166.65	$170.68	$138.38	$122.32
$112.31	$149.10	$152.70	$123.85	$109.52	71	$129.16	$171.46	$175.60	$142.42	$125.95
$115.02	$153.13	$156.82	$127.23	$112.57	72	$132.27	$176.10	$180.35	$146.32	$129.46
$117.45	$156.82	$160.60	$130.34	$115.38	73	$135.07	$180.34	$184.69	$149.89	$132.69
$119.57	$160.24	$164.10	$133.24	$118.02	74	$137.50	$184.27	$188.72	$153.23	$135.73
$122.58	$164.94	$168.92	$137.21	$121.63	75	$140.96	$189.68	$194.25	$157.80	$139.87
$126.75	$171.29	$175.41	$142.56	$126.46	76	$145.76	$196.98	$201.72	$163.95	$145.43
$128.39	$174.23	$178.42	$145.08	$128.79	77	$147.65	$200.37	$205.19	$166.84	$148.11
$131.17	$178.72	$183.02	$148.88	$132.26	78	$150.85	$205.53	$210.47	$171.22	$152.10
$132.61	$181.43	$185.79	$151.21	$134.42	79	$152.50	$208.65	$213.66	$173.89	$154.58
$134.06	$184.15	$188.57	$153.54	$136.58	80	$154.16	$211.78	$216.86	$176.57	$157.07
$135.40	$186.80	$191.28	$155.82	$138.71	81	$155.71	$214.82	$219.97	$179.19	$159.51
$137.96	$191.18	$195.76	$159.55	$142.13	82	$158.65	$219.86	$225.13	$183.48	$163.45
$139.09	$193.60	$198.24	$161.65	$144.11	83	$159.95	$222.64	$227.98	$185.90	$165.72
$140.12	$195.98	$200.67	$163.71	$146.06	84	$161.14	$225.37	$230.77	$188.27	$167.97
$142.45	$200.16	$204.95	$167.29	$149.37	85	$163.81	$230.19	$235.69	$192.38	$171.77
$143.40	$202.48	$207.31	$169.31	$151.29	86	$164.91	$232.85	$238.41	$194.71	$173.98
$144.37	$204.88	$209.77	$171.41	$153.28	87	$166.03	$235.61	$241.23	$197.12	$176.27
$145.34	$207.23	$212.17	$173.46	$155.23	88	$167.15	$238.32	$244.00	$199.48	$178.51
$146.33	$209.65	$214.64	$175.57	$157.23	89	$168.28	$241.10	$246.84	$201.90	$180.82
$148.73	$214.11	$219.20	$179.44	$160.83	90	$171.03	$246.22	$252.08	$206.36	$184.96
$149.76	$216.61	$221.76	$181.69	$162.97	91	$172.22	$249.10	$255.03	$208.95	$187.42
$150.83	$219.21	$224.42	$184.03	$165.20	92	$173.45	$252.10	$258.09	$211.63	$189.98
$151.93	$221.89	$227.15	$186.43	$167.48	93	$174.72	$255.17	$261.23	$214.39	$192.60
$153.06	$224.69	$230.02	$188.95	$169.88	94	$176.02	$258.40	$264.53	$217.29	$195.37
$155.63	$229.64	$235.08	$193.27	$173.91	95	$178.97	$264.09	$270.35	$222.26	$200.00
$156.71	$232.47	$237.97	$195.81	$176.34	96	$180.21	$267.33	$273.66	$225.18	$202.79
$157.89	$235.16	$240.72	$198.24	$178.67	97	$181.35	$270.43	$276.83	$227.98	$205.47
$158.65	$237.89	$243.52	$200.71	$181.05	98	$182.45	$273.58	$280.04	$230.82	$208.21
$159.63	$240.71	$246.39	$203.26	$183.50	99	$183.57	$276.81	$283.35	$233.74	$211.02

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

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 733, 750 - 753, 761, 782, 784, 793, 794

Standard Plans - Nonsmoker

Female					Attained	Male				
Plan A	Plan C	Plan F	Plan G	Plan N	Age	Plan A	Plan C	Plan F	Plan G	Plan N
$209.87	N/A	N/A	N/A	N/A	< 65	$241.35	N/A	N/A	N/A	N/A
$89.31	$118.03	$120.88	$98.00	$86.60	65	$102.70	$135.73	$139.01	$112.70	$99.59
$92.37	$121.92	$124.87	$101.21	$89.42	66	$106.23	$140.21	$143.60	$116.39	$102.83
$96.48	$127.16	$130.24	$105.54	$93.22	67	$110.95	$146.24	$149.77	$121.37	$107.20
$99.65	$131.36	$134.54	$109.02	$96.30	68	$114.59	$151.06	$154.71	$125.38	$110.74
$102.71	$135.68	$138.96	$112.63	$99.52	69	$118.12	$156.03	$159.80	$129.53	$114.45
$105.64	$139.87	$143.25	$116.15	$102.67	70	$121.48	$160.85	$164.74	$133.57	$118.07
$108.40	$143.91	$147.39	$119.54	$105.71	71	$124.66	$165.50	$169.50	$137.47	$121.57
$111.02	$147.80	$151.37	$122.81	$108.66	72	$127.67	$169.97	$174.07	$141.23	$124.95
$113.36	$151.36	$155.01	$125.81	$111.37	73	$130.37	$174.07	$178.27	$144.68	$128.07
$115.41	$154.67	$158.39	$128.61	$113.92	74	$132.72	$177.86	$182.15	$147.90	$131.01
$118.31	$159.21	$163.04	$132.44	$117.40	75	$136.06	$183.09	$187.50	$152.31	$135.01
$122.34	$165.33	$169.31	$137.60	$122.07	76	$140.69	$190.13	$194.71	$158.24	$140.37
$123.92	$168.17	$172.22	$140.03	$124.31	77	$142.51	$193.40	$198.05	$161.04	$142.96
$126.61	$172.51	$176.65	$143.70	$127.66	78	$145.60	$198.38	$203.15	$165.26	$146.81
$128.00	$175.12	$179.33	$145.95	$129.74	79	$147.20	$201.39	$206.23	$167.84	$149.20
$129.39	$177.75	$182.01	$148.20	$131.83	80	$148.80	$204.41	$209.32	$170.43	$151.61
$130.69	$180.30	$184.63	$150.40	$133.88	81	$150.29	$207.35	$212.32	$172.96	$153.96
$133.16	$184.53	$188.95	$154.00	$137.19	82	$153.13	$212.21	$217.29	$177.10	$157.77
$134.25	$186.87	$191.34	$156.03	$139.09	83	$154.39	$214.90	$220.05	$179.43	$159.96
$135.25	$189.16	$193.69	$158.02	$140.98	84	$155.54	$217.54	$222.74	$181.72	$162.13
$137.49	$193.20	$197.82	$161.47	$144.17	85	$158.12	$222.18	$227.49	$185.69	$165.80
$138.41	$195.43	$200.10	$163.42	$146.02	86	$159.17	$224.75	$230.12	$187.93	$167.93
$139.35	$197.75	$202.47	$165.44	$147.95	87	$160.25	$227.41	$232.84	$190.26	$170.14
$140.29	$200.02	$204.79	$167.42	$149.83	88	$161.33	$230.03	$235.51	$192.54	$172.30
$141.24	$202.36	$207.18	$169.46	$151.77	89	$162.43	$232.71	$238.25	$194.88	$174.53
$143.55	$206.66	$211.58	$173.20	$155.24	90	$165.09	$237.66	$243.32	$199.18	$178.52
$144.55	$209.08	$214.05	$175.37	$157.31	91	$166.23	$240.44	$246.16	$201.68	$180.90
$145.58	$211.59	$216.62	$177.63	$159.45	92	$167.42	$243.33	$249.11	$204.27	$183.37
$146.65	$214.17	$219.25	$179.94	$161.66	93	$168.64	$246.29	$252.14	$206.93	$185.90
$147.74	$216.88	$222.02	$182.37	$163.97	94	$169.90	$249.41	$255.33	$209.73	$188.57
$150.21	$221.66	$226.91	$186.55	$167.86	95	$172.75	$254.90	$260.94	$214.53	$193.04
$151.26	$224.38	$229.69	$189.00	$170.21	96	$173.94	$258.04	$264.15	$217.35	$195.74
$152.21	$226.98	$232.35	$191.34	$172.46	97	$175.04	$261.03	$267.20	$220.05	$198.33
$153.13	$229.62	$235.05	$193.73	$174.75	98	$176.10	$264.06	$270.30	$222.79	$200.97
$154.07	$232.34	$237.82	$196.19	$177.12	99	$177.19	$267.18	$273.49	$225.61	$203.68

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

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 733, 750 - 753, 761, 782, 784, 793, 794

Standard Plans - Smoker

Female					Attained	Male				
Plan A	Plan C	Plan F	Plan G	Plan N	Age	Plan A	Plan C	Plan F	Plan G	Plan N
$241.35	N/A	N/A	N/A	N/A	< 65	$277.55	N/A	N/A	N/A	N/A
$102.70	$135.73	$139.01	$112.70	$99.59	65	$118.11	$156.09	$159.86	$129.60	$114.53
$106.23	$140.21	$143.60	$116.39	$102.83	66	$122.16	$161.24	$165.14	$133.85	$118.25
$110.95	$146.24	$149.77	$121.37	$107.20	67	$127.59	$168.17	$172.24	$139.58	$123.28
$114.59	$151.06	$154.71	$125.38	$110.74	68	$131.78	$173.72	$177.92	$144.19	$127.35
$118.12	$156.03	$159.80	$129.53	$114.45	69	$135.84	$179.43	$183.77	$148.96	$131.61
$121.48	$160.85	$164.74	$133.57	$118.07	70	$139.70	$184.98	$189.45	$153.61	$135.78
$124.66	$165.50	$169.50	$137.47	$121.57	71	$143.36	$190.32	$194.92	$158.09	$139.80
$127.67	$169.97	$174.07	$141.23	$124.95	72	$146.82	$195.47	$200.19	$162.41	$143.70
$130.37	$174.07	$178.27	$144.68	$128.07	73	$149.92	$200.18	$205.01	$166.38	$147.28
$132.72	$177.86	$182.15	$147.90	$131.01	74	$152.63	$204.54	$209.48	$170.08	$150.66
$136.06	$183.09	$187.50	$152.31	$135.01	75	$156.47	$210.55	$215.62	$175.15	$155.26
$140.69	$190.13	$194.71	$158.24	$140.37	76	$161.80	$218.65	$223.91	$181.98	$161.43
$142.51	$193.40	$198.05	$161.04	$142.96	77	$163.89	$222.41	$227.76	$185.19	$164.40
$145.60	$198.38	$203.15	$165.26	$146.81	78	$167.44	$228.14	$233.62	$190.05	$168.83
$147.20	$201.39	$206.23	$167.84	$149.20	79	$169.28	$231.60	$237.16	$193.02	$171.58
$148.80	$204.41	$209.32	$170.43	$151.61	80	$171.12	$235.07	$240.71	$196.00	$174.35
$150.29	$207.35	$212.32	$172.96	$153.96	81	$172.84	$238.45	$244.17	$198.90	$177.06
$153.13	$212.21	$217.29	$177.10	$157.77	82	$176.10	$244.04	$249.89	$203.67	$181.43
$154.39	$214.90	$220.05	$179.43	$159.96	83	$177.55	$247.14	$253.05	$206.34	$183.95
$155.54	$217.54	$222.74	$181.72	$162.13	84	$178.87	$250.17	$256.15	$208.98	$186.45
$158.12	$222.18	$227.49	$185.69	$165.80	85	$181.83	$255.51	$261.61	$213.55	$190.67
$159.17	$224.75	$230.12	$187.93	$167.93	86	$183.05	$258.46	$264.63	$216.12	$193.12
$160.25	$227.41	$232.84	$190.26	$170.14	87	$184.29	$261.53	$267.77	$218.80	$195.66
$161.33	$230.03	$235.51	$192.54	$172.30	88	$185.53	$264.53	$270.84	$221.42	$198.15
$162.43	$232.71	$238.25	$194.88	$174.53	89	$186.79	$267.62	$273.99	$224.11	$200.71
$165.09	$237.66	$243.32	$199.18	$178.52	90	$189.85	$273.31	$279.81	$229.06	$205.30
$166.23	$240.44	$246.16	$201.68	$180.90	91	$191.17	$276.51	$283.08	$231.93	$208.04
$167.42	$243.33	$249.11	$204.27	$183.37	92	$192.53	$279.83	$286.47	$234.91	$210.88
$168.64	$246.29	$252.14	$206.93	$185.90	93	$193.94	$283.24	$289.96	$237.98	$213.79
$169.90	$249.41	$255.33	$209.73	$188.57	94	$195.38	$286.82	$293.63	$241.19	$216.86
$172.75	$254.90	$260.94	$214.53	$193.04	95	$198.66	$293.14	$300.09	$246.71	$222.00
$173.94	$258.04	$264.15	$217.35	$195.74	96	$200.04	$296.74	$303.77	$249.95	$225.10
$175.04	$261.03	$267.20	$220.05	$198.33	97	$201.30	$300.18	$307.28	$253.05	$228.08
$176.10	$264.06	$270.30	$222.79	$200.97	98	$202.52	$303.67	$310.85	$256.21	$231.11
$177.19	$267.18	$273.49	$225.61	$203.68	99	$203.76	$307.26	$314.52	$259.46	$234.24

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

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 770 through 777

Standard Plans - Nonsmoker

Female					*Attained*	*Male*				
Plan A	Plan C	Plan F	Plan G	Plan N	*Age*	Plan A	Plan C	Plan F	Plan G	Plan N
$236.34	N/A	N/A	N/A	N/A	< 65	$271.79	N/A	N/A	N/A	N/A
$100.57	$132.91	$136.13	$110.36	$97.53	65	$115.66	$152.85	$156.55	$126.91	$112.15
$104.02	$137.30	$140.62	$113.97	$100.70	66	$119.63	$157.89	$161.71	$131.07	$115.80
$108.65	$143.20	$146.67	$118.85	$104.98	67	$124.95	$164.68	$168.67	$136.68	$120.72
$112.21	$147.93	$151.50	$122.78	$108.44	68	$129.04	$170.12	$174.23	$141.19	$124.71
$115.67	$152.79	$156.48	$126.84	$112.07	69	$133.02	$175.71	$179.95	$145.87	$128.88
$118.96	$157.51	$161.32	$130.80	$115.62	70	$136.80	$181.14	$185.52	$150.42	$132.96
$122.08	$162.06	$165.98	$134.61	$119.04	71	$140.39	$186.37	$190.87	$154.81	$136.90
$125.02	$166.44	$170.46	$138.30	$122.36	72	$143.77	$191.41	$196.03	$159.04	$140.72
$127.66	$170.45	$174.57	$141.68	$125.41	73	$146.81	$196.02	$200.75	$162.93	$144.23
$129.97	$174.17	$178.37	$144.83	$128.29	74	$149.46	$200.30	$205.13	$166.55	$147.53
$133.23	$179.29	$183.60	$149.15	$132.21	75	$153.22	$206.18	$211.14	$171.52	$152.04
$137.77	$186.18	$190.67	$154.96	$137.46	76	$158.44	$214.11	$219.27	$178.20	$158.08
$139.55	$189.38	$193.94	$157.69	$139.99	77	$160.48	$217.79	$223.03	$181.35	$160.99
$142.58	$194.27	$198.93	$161.83	$143.76	78	$163.97	$223.41	$228.77	$186.10	$165.32
$144.14	$197.21	$201.95	$164.36	$146.10	79	$165.76	$226.79	$232.24	$189.01	$168.02
$145.71	$200.17	$204.97	$166.89	$148.46	80	$167.57	$230.19	$235.72	$191.93	$170.73
$147.17	$203.04	$207.91	$169.37	$150.77	81	$169.25	$233.50	$239.10	$194.77	$173.38
$149.95	$207.81	$212.78	$173.42	$154.49	82	$172.44	$238.98	$244.70	$199.44	$177.67
$151.18	$210.44	$215.48	$175.71	$156.64	83	$173.86	$242.01	$247.80	$202.06	$180.13
$152.31	$213.02	$218.12	$177.95	$158.76	84	$175.15	$244.97	$250.83	$204.64	$182.58
$154.83	$217.57	$222.77	$181.84	$162.35	85	$178.06	$250.20	$256.18	$209.11	$186.71
$155.87	$220.08	$225.34	$184.03	$164.44	86	$179.25	$253.10	$259.14	$211.84	$189.11
$156.93	$222.69	$228.01	$186.31	$166.61	87	$180.47	$256.10	$262.21	$214.26	$191.60
$157.98	$225.25	$230.62	$188.54	$168.73	88	$181.68	$259.04	$265.21	$216.82	$194.04
$159.05	$227.88	$233.31	$190.83	$170.91	89	$182.91	$262.06	$268.30	$219.46	$196.54
$161.68	$232.73	$238.27	$195.05	$174.82	90	$185.91	$267.64	$274.00	$224.30	$201.04
$162.78	$235.45	$241.05	$197.49	$177.15	91	$187.20	$270.77	$277.20	$227.12	$203.72
$163.94	$238.28	$243.94	$200.03	$179.56	92	$188.54	$274.02	$280.53	$230.04	$206.50
$165.14	$241.18	$246.91	$202.64	$182.05	93	$189.91	$277.36	$283.94	$233.03	$209.35
$166.37	$244.23	$250.03	$205.38	$184.65	94	$191.33	$280.87	$287.53	$236.18	$212.35
$169.16	$249.61	$255.53	$210.08	$189.03	95	$194.53	$287.05	$293.86	$241.59	$217.39
$170.33	$252.68	$258.66	$212.84	$191.67	96	$195.88	$290.58	$297.46	$244.76	$220.42
$171.41	$255.61	$261.65	$215.48	$194.21	97	$197.12	$293.95	$300.90	$247.80	$223.34
$172.45	$258.58	$264.69	$218.17	$196.80	98	$198.32	$297.37	$304.40	$250.89	$226.32
$173.51	$261.64	$267.82	$220.93	$199.46	99	$199.53	$300.88	$307.99	$254.07	$229.37

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

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 770 through 777

Standard Plans - Smoker

Female					*Attained*	*Male*				
Plan A	Plan C	Plan F	Plan G	Plan N	*Age*	Plan A	Plan C	Plan F	Plan G	Plan N
$271.79	N/A	N/A	N/A	N/A	< 65	$312.56	N/A	N/A	N/A	N/A
$115.66	$152.85	$156.55	$126.91	$112.15	65	$133.00	$175.78	$180.03	$145.95	$128.98
$119.63	$157.89	$161.71	$131.07	$115.80	66	$137.57	$181.57	$185.96	$150.73	$133.17
$124.95	$164.68	$168.67	$136.68	$120.72	67	$143.69	$189.38	$193.96	$157.18	$138.83
$129.04	$170.12	$174.23	$141.19	$124.71	68	$148.40	$195.63	$200.36	$162.37	$143.41
$133.02	$175.71	$179.95	$145.87	$128.88	69	$152.97	$202.06	$206.95	$167.75	$148.21
$136.80	$181.14	$185.52	$150.42	$132.96	70	$157.32	$208.31	$213.35	$172.98	$152.90
$140.39	$186.37	$190.87	$154.81	$136.90	71	$161.44	$214.33	$219.50	$178.03	$157.44
$143.77	$191.41	$196.03	$159.04	$140.72	72	$165.34	$220.12	$225.43	$182.90	$161.82
$146.81	$196.02	$200.75	$162.93	$144.23	73	$168.83	$225.42	$230.86	$187.37	$165.86
$149.46	$200.30	$205.13	$166.55	$147.53	74	$171.88	$230.34	$235.90	$191.53	$169.66
$153.22	$206.18	$211.14	$171.52	$152.04	75	$176.20	$237.10	$242.82	$197.24	$174.84
$158.44	$214.11	$219.27	$178.20	$158.08	76	$182.20	$246.23	$252.15	$204.93	$181.79
$160.48	$217.79	$223.03	$181.35	$160.99	77	$184.56	$250.46	$256.48	$208.55	$185.14
$163.97	$223.41	$228.77	$186.10	$165.32	78	$188.56	$256.92	$263.09	$214.02	$190.12
$165.76	$226.79	$232.24	$189.01	$168.02	79	$190.63	$260.81	$267.07	$217.36	$193.22
$167.57	$230.19	$235.72	$191.93	$170.73	80	$192.70	$264.72	$271.07	$220.72	$196.34
$169.25	$233.50	$239.10	$194.77	$173.38	81	$194.64	$268.52	$274.96	$223.99	$199.39
$172.44	$238.98	$244.70	$199.44	$177.67	82	$198.31	$274.82	$281.41	$229.35	$204.32
$173.86	$242.01	$247.80	$202.06	$180.13	83	$199.94	$278.31	$284.97	$232.37	$207.15
$175.15	$244.97	$250.83	$204.64	$182.58	84	$201.43	$281.72	$288.46	$235.34	$209.96
$178.06	$250.20	$256.18	$209.11	$186.71	85	$204.77	$287.73	$294.61	$240.48	$214.71
$179.25	$253.10	$259.14	$211.64	$189.11	86	$206.14	$291.06	$298.01	$243.38	$217.47
$180.47	$256.10	$262.21	$214.26	$191.60	87	$207.53	$294.51	$301.54	$246.40	$220.34
$181.68	$259.04	$265.21	$216.82	$194.04	88	$208.93	$297.89	$305.00	$249.35	$223.14
$182.91	$262.06	$268.30	$219.46	$196.54	89	$210.35	$301.37	$308.55	$252.38	$226.03
$185.91	$267.64	$274.00	$224.30	$201.04	90	$213.79	$307.78	$315.11	$257.95	$231.20
$187.20	$270.77	$277.20	$227.12	$203.72	91	$215.28	$311.38	$318.78	$261.18	$234.28
$188.54	$274.02	$280.53	$230.04	$206.50	92	$216.82	$315.12	$322.61	$264.54	$237.47
$189.91	$277.36	$283.94	$233.03	$209.35	93	$218.40	$318.96	$326.53	$267.99	$240.75
$191.33	$280.87	$287.53	$236.18	$212.35	94	$220.03	$323.00	$330.66	$271.61	$244.21
$194.53	$287.05	$293.86	$241.59	$217.39	95	$223.71	$330.11	$337.93	$277.82	$250.00
$195.88	$290.58	$297.46	$244.76	$220.42	96	$225.27	$334.17	$342.08	$281.47	$253.49
$197.12	$293.95	$300.90	$247.80	$223.34	97	$226.68	$338.04	$346.04	$284.97	$256.84
$198.32	$297.37	$304.40	$250.89	$226.32	98	$228.06	$341.97	$350.05	$288.53	$260.26
$199.53	$300.88	$307.99	$254.07	$229.37	99	$229.46	$346.02	$354.19	$292.18	$263.78

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$0	$1100 (Part A deductible)
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	$0	Up to $137.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

* Once You have been billed $155 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $155 of Medicare-approved amounts*	$0	$0	$155 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
(Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $155 of Medicare-approved amounts*	$0	$0	$155 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$0	$155 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$1100 (Part A deductible)	$0
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the Policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

* Once You have been billed $155 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $155 of Medicare-approved amounts*	$0	$155 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $155 of Medicare-approved amounts*	$0	$155 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$155 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$1100 (Part A deductible)	$0
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

***NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

* Once You have been billed $155 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $155 of Medicare-approved amounts*	$0	$155 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $155 of Medicare-approved amounts*	$0	$155 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$155 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$1100 (Part A deductible)	$0
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

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

* Once You have been billed $155 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $155 of Medicare-approved amounts*	$0	$0	$155 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
(Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $155 of Medicare-approved amounts*	$0	$0	$155 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$0	$155 (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 emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$1100 (Part A deductible)	$0
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

* Once You have been billed $155 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First $155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	 $155 (Part B deductible) Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next $155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $155 (Part B deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES • Medically necessary skilled care services and medical supplies • Durable medical equipment First $155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% $0 80%	$0 $0 20%	$0 $155 (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

Agent checklist for completing the Medicare Supplement / Life Insurance Application

FORE THOUGHT®

This packet contains the following forms needed to complete an Application For Medicare Supplement Insurance and Life 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 and Life 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
  - Life Insurance – Section 4 is required when the applicant(s) is applying for life insurance
  - Section 7 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 to calculate the correct life insurance premium and, 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 **or** if applying for life insurance. 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).
- ❑ Notice for Replacement of Life Insurance or Annuities (A7012-02) – This form must be completed if replacement of existing life insurance 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, Medical Information Bureau Disclosure Notice, Medicare Supplement/ Select Initial Premium Receipt, and Life Insurance Conditional Coverage receipt (MSREC-01) – The Initial/Conditional Premium Receipts 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 and policy fee

Utilize the Forethought® ForeLife℠ final expense premium chart to determine the correct monthly life insurance premium. 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 Plan
- Determine if tobacco or non-tobacco use
- Find age/gender – Verify that the age and date of birth are the exact age as of the application date, this will be your base monthly premium
- Use the Calculate your premium form to adjust the monthly premium for different modes and to add the policy fee

There will be a one-time Medicare Supplement application fee of $25.00 that must be collected with each applicant's initial payment. If both spouses are written on the same application, $50.00 in fees must be collected. This will not affect the renewal premiums.

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
2536 Countryside Boulevard, Suite 501
Clearwater, FL 33763

FAX Number for New Business - EFT Applications 1-800-497-6115

FORE THOUGHT®

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE AND LIFE 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 Agent)

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

APPLICANT					
Medicare Supplement Standard Plan	☐ A	☐ C	☐ F	☐ G	☐ N
Medicare Supplement Select Plan (not available in all states)	☐ C	☐ F	☐ G	☐ N	
Requested Effective Date	Mail Policy To ☐ Insured	☐ Agent			
Initial Premium Collected $	Renewal Premium $				
Renewal Premium Mode ☐ Annual	☐ Semi-Annual	☐ Quarterly	☐ Monthly EFT		

APPLICANT B					
Medicare Supplement Standard Plan	☐ A	☐ C	☐ F	☐ G	☐ N
Medicare Supplement Select Plan (not available in all states)	☐ C	☐ F	☐ G	☐ N	
Requested Effective Date	Mail Policy To ☐ Insured	☐ Agent			
Initial Premium Collected $	Renewal Premium $				
Renewal Premium Mode ☐ Annual	☐ Semi-Annual	☐ Quarterly	☐ Monthly EFT		

SECTION 1 - IF APPLYING FOR MEDICARE SUPPLEMENT INSURANCE AND/OR LIFE INSURANCE, 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			

FOR AGENT USE ONLY: Application for: ☐ Medicare Supplement ☐ Life Insurance

SECTION 2 – IF APPLYING FOR MEDICARE SUPPLEMENT INSURANCE, 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

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 that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark YES or NO below with an "X" to the best of your knowledge.

1. Did you turn age 65 in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
2. Did you enroll in Medicare Part B in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
3. If yes, what is the effective date. _____/_____ (Applicant / Applicant B)		
4. Are you covered for medical assistance through the state Medicaid program?	☐ Yes ☐ No	☐ Yes ☐ No
a. 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.		
b. If yes;		
(i) Will Medicaid pay your premiums for this Medicare supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No
(ii) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	☐ Yes ☐ No	☐ Yes ☐ No
5. 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 __/__/___		
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. Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
c. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
6. Do you have another Medicare supplement policy in force?	☐ Yes ☐ No	☐ Yes ☐ No
a. If so, with what company, and what plan do you have?		
b. If so, do you intend to replace your current Medicare supplement policy with this policy?	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)	☐ Yes ☐ No	☐ Yes ☐ No
a. If so, with what company and what kind of policy?		
b. What are your dates of coverage under the other policy? START __/__/___ END __/__/___ START __/__/___ END __/__/___ (If you are still covered under the other policy, leave "END" BLANK)		
8. Agents shall list the following;		
a. Any other insurance policies or coverages sold to the applicant which are still in force; and	☐ Yes ☐ No	☐ Yes ☐ No
b. Any other health insurance policies or coverages sold to the applicant in the past five years which are no longer in force.	☐ Yes ☐ No	☐ Yes ☐ No
9. Are you covered under Medicare Part A:	☐ Yes ☐ No	☐ Yes ☐ No
a. If yes; what is your Part A effective date? _____/_____ (Applicant / Applicant B)	☐ Yes ☐ No	☐ Yes ☐ No
b. If no; what is your eligibility date? _____/_____ (Applicant / Applicant B)	☐ Yes ☐ No	☐ Yes ☐ No
10. Are you covered under Medicare Part B?		
a. If yes; what is your Part B effective date: _____/_____ (Applicant / Applicant B)		
b. If no; indicate date you plan to enroll _____/_____ (Applicant / Applicant B)	☐ Yes ☐ No	☐ Yes ☐ No

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

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)?	☐ Yes ☐ No	☐ Yes ☐ No
(a) If "YES," please complete the following:		

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 _____ (Applicant) / START_____ END _____ (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**?	☐ Yes ☐ No	☐ Yes ☐ No
(c) Reason for termination/disenrollment? _____ (Applicant) / _____ (Applicant B)	☐ Yes ☐ No	☐ Yes ☐ No
(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.)	☐ Yes ☐ No	☐ Yes ☐ No
(a) If "YES," with what company and what kind of policy/certificate?(list below)		

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 _____ (Applicant) / START_____ END _____ (Applicant B)

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

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

SECTION 4

IF APPLYING FOR ONLY MEDICARE SUPPLEMENT INSURANCE:

- During Open Enrollment or a Guaranteed Issue period, SKIP SECTION 4 and GO TO SECTION 5.
- NOT during Open Enrollment or a Guaranteed Issue period, PLEASE ANSWER ALL QUESTIONS.

IF APPLYING FOR LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS. If either you or Applicant B answer "YES" to any of the following questions 1-14, that person is not eligible for Medicare Supplement or Life Insurance 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 ever been diagnosed as having or told by a medical doctor that you have Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) Disorders, or the Human Immune Deficiency 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 – IF APPLYING FOR WHOLE LIFE INSURANCE, PLEASE COMPLETE ALL QUESTIONS

NOTE: If you are in Open Enrollment or eligible for Guaranteed Issue for a Medicare Supplement policy and are applying for Whole Life Insurance, you MUST answer all the questions in SECTION 4 of the application.

APPLICANT		
Beneficiary Name	Relationship To Applicant	Face Amount: ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ Other _____ Automatic Premium Loan – *if available* ☐ Yes ☐ No
Life Insurance Premium remitted with application $	Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT	

APPLICANT B *(if applying for coverage)*		
Beneficiary Name	Relationship To Applicant	Face Amount: ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ Other _____ Automatic Premium Loan – *if available* ☐ Yes ☐ No
Life Insurance Premium remitted with application $	Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT	

SECTION 6 - REPLACEMENT

	APPLICANT	**APPLICANT B**
1. Are there any existing life insurance policies on the life of the applicant?	☐ Yes ☐ No	☐ Yes ☐ No
2. Is this life insurance intended to replace or change any existing life insurance policy or annuity? ***NOTE**: If "YES," complete the appropriate Forethought Replacement form for the state where the applicant resides and submit with the application form.*	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 7 - 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

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 8 - 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 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.
- 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.

☐ A Life insurance policy. I understand that, (a) no insurance will take effect until the premium has been paid and a policy has been issued while the Insured is living, the first premium has been paid, and my insurability as stated in this application remains unchanged; (b) acceptance of the life insurance policy issued on this application shall constitute agreement to any correction or amendment of this application made by Forethought and noted on this application; (c) no change in amount, age at issue, plan of insurance or benefit applied for shall be made unless agreed to in writing by me; and (d) during the contestable period, Forethought has the right to rescind any life insurance policy issued upon statements or answers in this application that are not correct.

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

Do you have any knowledge or reason to believe that this application replaced existing life insurance? ☐ Yes ☐ No

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)

Definitions of Eligible Person for Guaranteed Issue and Creditable Coverage

Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:
   (a) The certification of the organization or plan has been terminated; or
   (b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
   (c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851 (g)(3)(B) of the Social Security Act (where the behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;
   (d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:
      1. The organization offering the plan substantially violated a material provision of the organization's contract under U.S.C Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered case in accordance with applicable quality standards; or
      2. The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
   (e) The individual meets such other exceptional conditions as the Secretary may provide.

(3) The individual is enrolled with an entity listed in subparagraphs (A) - (D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) of this subsection:
   (a) An eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost)'
   (b) A similar organization operating under a contract under demonstration project authority, effective for periods before April 1, 1999;
   (c) An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
   (d) An organization under a Medicare Select policy; and

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
   (a) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of involuntary termination of coverage or enrollment under the policy;
   (b) The issuer of the policy is substantially violated a material provision of the policy; or
   (c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or

(6) The individual, upon first becoming enrolled in Medicare part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

(7) The Individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that cover outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D with the application for a policy described in subsection (c)(4) of this section.

(8) The individual loses eligibility for health benefits under Medicaid.

Definitions of Eligible Person for Guaranteed Issue and Creditable Coverage (continued)

Creditable Coverage means (a) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); (b) a group health benefit plan provided by a health insurance carrier or an HMO; (c) an individual health insurance certificate or evidence of coverage; (d) Part A or Part B of Title XVIII of the Social Security Act; (e) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (f) Chapter 55 of Title 10 (CHAMPUS); (g) a medical care program of the Indian Health Service or of a tribal organization; (h) a state or political subdivision health benefits risk pool; (i) a health plan offered under Chapter 89 of Title 5 (Federal Employees Health Benefits Program); (j) a public health plan (as defined in federal regulation); (k) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)); or (l) short-term limited duration insurance.

Creditable Coverage does not include: (a) accident only, disability income insurance, or a combination of accident-only and disability income insurance; (b) coverage issued as a supplement to liability insurance; (c) liability insurance, including general liability insurance and automobile liability insurance; (d) workers' compensation or similar insurance; (e) automobile medical payment insurance; (f) credit only insurance; (g) coverage for onsite medical clinics; (h) other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations; (i) if offered separately, coverage that provides limited scope dental and vision benefits; (j) if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits; (k) if offered separately, coverage for other limited benefits specified by federal regulations; (l) if offered as independent, noncoordinated benefits, coverage for specified disease or illness; (m) if offered as independent, noncoordinated benefits, hospital indemnity or other fixed indemnity insurance; or (n) Medicare supplemental health insurance as defined under Section 1882 (g)(1), Social Security Act (42 USC Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 USC Section 1071 et. seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

Agent Certification

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

FORETHOUGHT®

I the undersigned insurance agent certify;

THAT, I have taken an application for:

Primary insured:		**Applicant B:**	
Medicare Supplement Standard	Medicare Supplement Select	Medicare Supplement Standard	Medicare Supplement Select
❑ Plan A	❑ Plan C	❑ Plan A	❑ Plan C
❑ Plan C	❑ Plan F	❑ Plan C	❑ Plan F
❑ Plan F	❑ Plan G	❑ Plan F	❑ Plan G
❑ Plan G	❑ Plan N	❑ Plan G	❑ Plan N
❑ Plan N		❑ Plan N	

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 ❑ Money order ❑ 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

RETURN TO COMPANY

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, treatment, 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. I understand 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

Forethought® ForeLife℠
Final Expense Life Insurance

FORE THOUGHT®

Forethought® ForeLife℠ is a whole life insurance product designed to help cover final expenses such as the costs associated with funeral and burial expenses. The ForeLife product provides guaranteed, level premiums and uses the same simplified application as the Forethought® Medicare Supplement Standard and Select Plans.

- Minimum face amount – $5,000
- Maximum face amount – $30,000 full death benefit
  $20,000 graded death benefit
- Policy is rated on age at last birthday – may backdate 6 months to save age.
- Please refer to the ForeLife Height and Weight chart for eligibility.
- Monthly bank draft premiums are displayed on the rate chart.
  - Other modal premiums available are quarterly, semi-annual and annual. See rate chart for modal factors.
- Underwriting Classes are Smoker and Non-Smoker.
  - A smoker is considered anyone who has smoked cigarettes in the past 12 months.
- One check for both a Medicare Supplement policy and a ForeLife policy is acceptable.
- The Calculate your premium form must be completed and submitted with application.

Death benefit	Months 1-12	Months 13-24	Months 25-36	Months 37+
Full benefit	100% of face	100% of face	100% of face	100% of face
Graded benefit* (Accidental Death - 100% of face)	25% of face	50% of face	75% of face (NH, NJ – 100% of face)	100% of face

* Not available in all states.

Please advise your client that a phone interview will be conducted within the next few days so they will be prepared to receive the call.

This is only a brief description of the policy guidelines. Please refer additional questions to your licensed insurance agent.

Monthly rates

Monthly EFT premium rates – full death benefit coverage only

Female									Male							
Per $1,000		$5,000		$7,500		$10,000			Per $1,000		$5,000		$7,500		$10,000	
NS	S	NS	S	NS	S	NS	S	Ages	NS	S	NS	S	NS	S	NS	S
$3.98	$5.54	$23.27	$31.05	$33.22	$44.89	$43.16	$58.73	65	$5.10	$7.61	$28.89	$41.43	$41.65	$60.46	$54.41	$79.49
$4.15	$5.80	$24.13	$32.35	$34.51	$46.84	$44.89	$61.33	66	$5.36	$8.13	$30.19	$44.03	$43.60	$64.36	$57.00	$84.68
$4.41	$6.06	$25.43	$33.65	$36.46	$48.79	$47.49	$63.92	67	$5.71	$8.65	$31.92	$46.62	$46.19	$68.25	$60.46	$89.87
$4.67	$6.31	$26.73	$34.95	$38.41	$50.73	$50.08	$66.52	68	$6.06	$9.17	$33.65	$49.22	$48.79	$72.14	$63.92	$95.06
$4.93	$6.57	$28.03	$36.24	$40.35	$52.68	$52.68	$69.11	69	$6.40	$9.69	$35.38	$51.81	$51.38	$76.03	$67.38	$100.25
$5.19	$6.92	$29.32	$37.97	$42.30	$55.27	$55.27	$72.57	70	$6.83	$10.21	$37.54	$54.41	$54.62	$79.93	$71.71	$105.44
$5.45	$7.44	$30.62	$40.57	$44.24	$59.17	$57.87	$77.76	71	$7.35	$10.81	$40.14	$57.44	$58.52	$84.47	$76.90	$111.50
$5.80	$7.96	$32.35	$43.16	$46.84	$63.06	$61.33	$82.95	72	$7.87	$11.50	$42.73	$60.90	$62.41	$89.66	$82.09	$118.42
$6.14	$8.48	$34.08	$45.76	$49.43	$66.95	$64.79	$88.14	73	$8.39	$12.20	$45.33	$64.36	$66.30	$94.85	$87.28	$125.34
$6.49	$9.00	$35.81	$48.35	$52.03	$70.84	$68.25	$93.33	74	$8.91	$12.98	$47.92	$68.25	$70.19	$100.69	$92.47	$133.12
$6.92	$9.52	$37.97	$50.95	$55.27	$74.74	$72.57	$98.52	75	$9.43	$13.84	$50.52	$72.57	$74.09	$107.17	$97.66	$141.77
$7.44	$10.21	$40.57	$54.41	$59.17	$79.93	$77.76	$105.44	76	$10.03	$14.71	$53.54	$76.90	$78.63	$113.66	$103.71	$150.42
$8.04	$10.99	$43.60	$58.30	$63.71	$85.76	$83.82	$113.23	77	$10.73	$15.66	$57.00	$81.66	$83.82	$120.80	$110.63	$159.94
$8.65	$11.76	$46.62	$62.19	$68.25	$91.60	$89.87	$121.01	78	$11.50	$16.69	$60.90	$86.85	$89.66	$128.58	$118.42	$170.32
$9.43	$12.63	$50.52	$66.52	$74.09	$98.09	$97.66	$129.66	79	$12.46	$17.82	$65.65	$92.47	$96.79	$137.02	$127.93	$181.56
$10.29	$13.49	$54.84	$70.84	$80.57	$104.58	$106.31	$138.31	80	$13.41	$19.03	$70.41	$98.52	$103.93	$146.10	$137.45	$193.67
$11.25	$14.36	$59.60	$75.17	$87.71	$111.07	$115.82	$146.96	81	$14.45	$20.24	$75.60	$104.58	$111.71	$155.18	$147.83	$205.78
$12.20	$15.31	$64.36	$79.93	$94.85	$118.20	$125.34	$156.48	82	$15.48	$21.54	$80.79	$111.07	$119.50	$164.91	$158.21	$218.76
$13.15	$16.35	$69.11	$85.12	$101.98	$125.99	$134.85	$166.86	83	$16.52	$22.92	$85.98	$117.99	$127.28	$175.29	$168.59	$232.60
$14.10	$17.47	$73.87	$90.74	$109.12	$134.42	$144.37	$178.10	84	$17.56	$24.39	$91.17	$125.34	$135.07	$186.32	$178.97	$247.30
$15.14	$18.68	$79.06	$96.79	$116.90	$143.50	$154.75	$190.21	85	$18.60	$25.95	$96.36	$133.12	$142.85	$198.00	$189.35	$262.87

To estimate the monthly premium for face amounts other than $5,000, $7,500, or $10,000, multiply the "Per $1,000" factor by the desired face amount, divide by $1,000 and add a $3.37 monthly policy fee.

For quarterly premium mode, multiply the monthly premium by 3.01

For semi-annual premium mode, multiply the monthly premium by 5.95

For annual premium mode, multiply the monthly premium by 11.56

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 go to page 2 to determine your eligibility for coverage.*

Steps	**Example** Rate displayed is used for calculation purposes only.	Applicant's premium	Applicant B's premium
Premium Write in your Medicare Supplement Plan's premium from the Outline of Coverage table.	$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		
Enrollment/Policy fee There is a one-time application fee of $25.00 **This will be collected with your initial payment and will NOT affect your renewal premium.**	$128.52 + $25.00 = $153.52 Example shows initial payment (monthly schedule).		

Calculate your premium

Forethought® Life Insurance

TO ADD FORETHOUGHT® FORELIFE℠

For total face amounts other than $5,000, $7,500, or $10,000, multiply the "Per $1,000" column by the number of units applied for and add the $3.37 monthly policy fee to your calculation.			Applicant's premium calculation	Applicant B's premium calculation
Choose the base face amount of life insurance coverage you want to purchase ($5,000, $7,500 or $10,000)	Base face amount $5,000 (Example based on Male age 75 non-smoker)	Premium amount $50.52		
Add any additional $1,000 Face Amount increments	1 Additional $1,000 increment x $9.43 per $1,000	Total additional increment premium = $9.43		
Payment Options Multiply monthly premium by: $3.08 for a quarterly premium $5.95 for a semi-annual premium $11.56 for an annual premium **BILLING MODE MUST BE THE SAME AS THE MEDICARE SUPPLEMENT BILLING MODE**	$50.52 base premium + $9.43 additional increment $59.95 total monthly premium for life insurance x3.08 (Quarterly) = $184.65 x5.95 (Semi-annual)=$356.70 x11.56 (Annual) = $693.02	Total life premium $50.52 + $9.43 $59.95		
Add the Medicare Supplement (from top section) and Life Insurance premiums (this section) together	$153.52 (Med Supp) + $59.95 (Life Ins) $213.47	One check payable to Forethought Life Insurance Company for $213.47		

COMPLETE AND RETURN WITH APPLICATION

Height and weight charts

To determine whether you may purchase coverage, locate your height, then weight in the charts below. If your weight is not in the Standard column for either product, we're sorry, you're not eligible for coverage at this time. If your weight is located in the Standard column for one or both products, 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 +
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 +

FORETHOUGHT® FORELIFE℠ LIFE INSURANCE

	Decline	Standard	Decline
Height	Weight	Weight	Weight
4′ 7″	< 80	80 – 172	173 +
4′ 8″	< 84	84 – 179	180 +
4′ 9″	< 87	87 – 186	187 +
4′ 10″	< 90	90 – 193	194 +
4′ 11″	< 93	93 – 199	200 +
5′ 0″	< 96	96 – 206	207 +
5′ 1″	< 99	99 – 213	214 +
5′ 2″	< 103	103 – 220	221 +
5′ 3″	< 106	106 – 227	228 +
5′ 4″	< 109	109 – 234	235 +
5′ 5″	< 112	112 – 241	242 +
5′ 6″	< 116	116 – 248	249 +
5′ 7″	< 119	119 – 255	256 +
5′ 8″	< 123	123 – 263	264 +
5′ 9″	< 126	126 – 270	271 +
5′ 10″	< 129	129 – 277	278 +
5′ 11″	< 133	133 – 285	286 +
6′ 0″	< 137	137 – 293	294 +
6′ 1″	< 140	140 – 301	302 +
6′ 2″	< 144	144 – 309	310 +
6′ 3″	< 148	148 – 318	319 +
6′ 4″	< 152	152 – 326	327 +
6′ 5″	< 155	155 – 333	334 +
6′ 6″	< 160	160 – 342	343 +
6′ 7″	< 164	164 – 351	352 +
6′ 8″	< 168	168 – 359	360 +
6′ 9″	< 171	171 – 367	368 +
6′10″	< 175	175 – 376	377 +
6′11″	< 180	180 – 385	386 +

FORE THOUGHT®

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

FORETHOUGHT LIFE INSURANCE COMPANY
ONE FORETHOUGHT CENTER
BATESVILLE, INDIANA 47006
INSURANCE – 800/331-8853
ANNUITIES – 877/244-7526

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.
You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ❑ **Yes** ❑ **No**

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ❑ **Yes** ❑ **No**

If you answered ***"Yes"*** to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME & ADDRESS	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.
I certify that the responses herein are, to the best of my knowledge, accurate:

_____
Applicant's Signature and Printed Name *Date*

_____
Producer's Signature and Printed Name *Date*

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A7012-02

LEAVE WITH APPLICANT

LIFE INSURANCE AND ANNUITIES REPLACEMENT MODEL REGULATION

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: *Are they affordable?*
Could they change?
You're older – are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: *New policies usually take longer to build cash values and to pay dividends.*
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY: *If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.*
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from the death benefits?
What values from the old policies are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

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A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ **Yes** ☐ **No**

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If you answered ***"Yes"*** to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME & ADDRESS	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
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Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.
I certify that the responses herein are, to the best of my knowledge, accurate:

_____
Applicant's Signature and Printed Name *Date*

_____
Producer's Signature and Printed Name *Date*

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A7012-02

RETURN TO COMPANY

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

Forethought Life Insurance Company
Administrative Office
P.O. Box 14659 · Clearwater, FL 33766-4659

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by Forethought Life Insurance Company. Your new policy will provide 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 or Medicare Advantage coverage only 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 evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY ISSUER

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 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 reasons:

- ❑ Additional Benefits,
- ❑ Same benefits but lower premiums,
- ❑ Fewer benefits and lower premiums,
- ❑ My plan has outpatient prescription drug coverage and I am enrolling in Part D,
- ❑ Disenrollment from a Medicare Advantage plan.
  Please explain reason for disenrollment._____
  _____
- ❑ Other - (specify)
  _____

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

(1) 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.

(2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions waiting periods, elimination periods, or probationary periods. The insurer will reduce any time periods applicable to pre-existing conditions waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent

LEAVE WITH APPLICANT

such time was spent (depleted) under the original policy.

(3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical 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.

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

_____

Signature of Agent or Other Representative

_____

Typed Name and Address of Issuer or Agent

_____

Applicant's Signature

Applicant B Signature – IF APPLYING

_____

Date

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

Forethought Life Insurance Company
Administrative Office
P.O. Box 14659 · Clearwater, FL 33766-4659

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You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only 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 evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY ISSUER

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 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 reasons:

- ❑ Additional Benefits,
- ❑ Same benefits but lower premiums,
- ❑ Fewer benefits and lower premiums,
- ❑ My plan has outpatient prescription drug coverage and I am enrolling in Part D,
- ❑ Disenrollment from a Medicare Advantage plan.
  Please explain reason for disenrollment._____
  _____
- ❑ Other - (specify)
  _____

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

(1) 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.

(2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions waiting periods, elimination periods, or probationary periods. The insurer will reduce any time periods applicable to pre-existing conditions waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent

RETURN TO COMPANY

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(3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical 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.

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

_____

Signature of Agent or Other Representative

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Typed Name and Address of Issuer or Agent

_____

Applicant's Signature

Applicant B Signature – IF APPLYING

_____

Date

Forethought Life Insurance Company
Administrative Office
P.O. 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.

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Forethought Life Insurance Company (the Company) or its 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 member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB'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 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

Initial Premiums Paid through ACH (Automated Clearing House)
Medicare Supplement / Life applications may have their initial premium automatically deducted from their checking or savings account through the specific 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 / Life 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 complete the appropriate Medicare Supplement / Life Authorization for Electronic Funds Transfer section on the application.

STEP 2 – FAX THE FOLLOWING ITEMS TO THE DEDICATED LINE FOR ACH PAYMENTS AT 1-800-497-6115

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

2) Medicare Supplement / Life Application and other required forms including authorization 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.

FORE THOUGHT®

Forethought Life Insurance Company

FAX TRANSMITTAL

FOR USE WITH EFT MONTHLY PREMIUM APPLICATIONS ONLY

1-800-497-6115

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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