2012 STANDARD Medicare Supplement/ Life Insurance Plans

Issued by Forethought Life Insurance Company



THINKING AHEAD^{5M} THOUGHT[®]

2012 Forethought[®] Standard Medicare Supplement Insurance Plans

You can rely on Forethought[®] Standard Medicare Supplement Plans to help pay your Medicare Part A and Medicare Part B charges that Medicare doesn't cover.

What's more, you have:

- Five plans from which to select the coverage that best meets your needs.
- 30 days to review your Policy; if you're not happy with it, we'll refund your premium.
- Virtually no claims paperwork to file.



The Forethought Standard Medicare Supplement insurance is underwritten by:

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

Choose the Forethought Standard Medicare Supplement Plan that's right for you.

Choose the Forethought[®] plan that best fits your needs!

	MEDICARE PAYS	PLAN A PAYS	PLAN C PAYS	PLAN F PAYS	PLAN G PAYS	PLAN N PAYS
	re Part A Coverage					
Deductible			\$1,156	\$1,156	\$1,156	\$1,156
First 60 days	100%					
Coinsurance 61–90 days	All but \$289 a day	\$289 a day	\$289 a day	\$289 a day	\$289 a day	\$289 a day
Coinsurance 91–150 days (Lifetime Reserve)	All but \$578 a day	\$578 a day	\$578 a day	\$578 a day	\$578 a day	\$578 a day
Extended hospital coverage (up to an additional 365 days in your lifetime)		Eligible expenses	Eligible expenses	Eligible expenses	Eligible expenses	Eligible expenses
Benefit for blood	All but 3 pints	3 pints	3 pints	3 pints	3 pints	3 pints
Hospie	ce Care					
	All but limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance
Skilled Facilit	Nursing ty Care					
First 20 days	100%					
Coinsurance 21–100 days	All but \$144.50 a day		Up to \$144.50 a day			
Physician	re Part B 's Services upplies					
Deductible			\$140	\$140		
Coinsurance	Generally 80%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20% ⁺
Excess benefits				100% up to Medicare's limit	100% up to Medicare's limit	
Benefit for blood	All but 3 pints	3 pints	3 pints	3 pints	3 pints	3 pints
Other I	Benefits*					
Emergency care received outside the USA			80% to lifetime max of \$50,000			

*Refer to the next page and your Outline of Coverage for more information.

⁺ Subject to copayment for office and emergency room visits.

Medicare Part A hospital coverage

The Forethought[®] Standard Medicare Supplement Plan pays the \$1,156 Part A (inpatient) deductible for Plans C, F, G and N for each benefit period.

First 60 days – After the Part A deductible, Medicare pays all eligible expenses for services from your first through 60th day of hospital confinement. Services include semi-private room and board, general nursing and miscellaneous hospital services and supplies.

Coinsurance – Plans A, C, F, G and N pay \$289 a day when you are hospitalized from the 61st day through the 90th day. When you are hospitalized from the 91st day through the 150th day, the Plans pay \$578 a day for each Lifetime Reserve day used.

Extended hospital coverage – If you are in the hospital longer than 150 days during a benefit period and you have exhausted your 60 days of Medicare lifetime reserve, Plans A, C, F, G and N pay the Part A Medicare eligible expenses for hospitalization, paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

Benefit for blood – Medicare has one calendar year deductible for blood that is the cost of the first three pints. Plans A, C, F, G and N pay the deductible.

Skilled nursing facility care – Medicare pays all eligible expenses for the first 20 days.

Coinsurance – Plans C, F, G and N pay up to \$144.50 from the 21st through the 100th day during which you receive skilled nursing care. You must enter a Medicare certified skilled nursing facility within 30 days of being hospitalized for at least three days.

Hospice care benefit – Plans A, C, F, G and N pay the copayment/coinsurance amount for all Part A Medicare eligible hospice care and respite care expenses.

Medicare Part B physician services and supplies

Deductible – Plans C and F pay the \$140 calendaryear deductible.

Coinsurance – After the Part B deductible, Plans A, C, F and G generally pay 20% of eligible expenses for physician's services, supplies, physical and speech therapy, and ambulance service.

After the Part B deductible, Plan N generally pays 20% of the eligible expenses for physician's services, supplies, physical and speech therapy, and ambulance services except up to a \$20 copayment for office visits and up to a \$50 copayment for emergency room visits.

For hospital outpatient services, the copayment amount will be paid under a prospective payment system. If this system is not used, then generally 20% of eligible expenses will be paid.

Excess benefits – Your bill for Part B services and supplies may exceed the Medicare eligible expense. When that occurs, Plan F and G will pay 100% up to the charge limitation established by Medicare.

Benefit for blood – Medicare has one calendar year deductible for blood that is the cost of the first three pints. Plans A, C, F, G and N pay the deductible.

Other benefits*

Emergency care received outside the U.S. – After you pay a calendar-year deductible, Plans C, F, G and N pay you 80% of eligible expenses incurred during the first 60 days of a trip up to a lifetime maximum of \$50,000. Benefits are payable for medically necessary emergency care.

^{*}Refer to the next page and your Outline of Coverage for more information.

Forethought[®] Medicare Supplement Plans

A Forethought[®] Standard Medicare Supplement insurance policy helps pay eligible expenses not paid for by Medicare Part A and Medicare Part B. There may be charges that exceed what Medicare and your Standard Medicare Supplement insurance policy will pay.

"Medicare Eligible Expenses" means expenses covered by Medicare to the extent recognized as reasonable and medically necessary by Medicare.

Forethought Standard Medicare Supplement Plans will not pay for:

- Any expense incurred before your Policy Date
- Services for which no charge is made
- Expenses paid by Medicare
- Hospital or skilled nursing facility confinement charges incurred prior to the effective date of coverage of the policy
- Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate

Medicare Part A Eligible Expenses for hospital/ skilled nursing facility care include

expenses for semi-private room and board, general nursing and miscellaneous services and supplies.

A **Benefit Period** begins the first full day you are hospitalized and ends when you have not been in a hospital or skilled nursing facility for 60 consecutive days.

Medicare Part B Eligible Expenses for medical

services include expenses for physician's services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service.

Coinsurance is the portion of the eligible expense not paid by Medicare and paid by Standard Medicare Supplement Plans.

Benefits are paid to you, your hospital or doctor.

You have 31 days from your renewal date to pay your premium. Your policy will stay inforce during this 31-day grace period.

Your Policy is guaranteed renewable. Your policy cannot be canceled. It will be renewed as long as the premiums are paid on time and the information on your application is correct.

You cannot be singled out for a rate increase no matter how many times you receive benefits. Your premium changes only (a) each year on the renewal date coinciding with or following the anniversary of your Policy Date until you reach age 99; and (b) when the same premium change is made on all inforce Forethought Standard Medicare Supplement policies of the same form issued to persons of your classification in the same geographic area of your state.

This is a brief description of your coverage. This brochure must be accompanied by the Outline of Coverage. For a complete description of benefits, exceptions and limitations, please read your Outline of Coverage and your Policy.

Not connected with or endorsed by the United States government or the federal Medicare program.

This is a solicitation of insurance and an agent will contact you by telephone.

*Refer to the next page and your Outline of Coverage for more information.

Forethought Life Insurance Company Administrative Office P.O. Box 14659, Clearwater, FL 33766-4659 (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 coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or copayment for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Hospice: Part

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Basic, including 100% Part B 10 coinsurance co	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, Including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50	
		Chilled	CLiller	Chilled	CL;II, 24				copayment for EK	
		экшеа Nursing Facility coinsurance	ыкшеа Nursing Facility coinsurance	экшеа Nursing Facility coinsurance	экшеа Nursing Facility coinsurance	50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	
	Part A	Part A	Part A	Part A	Part A	collibulation	rullouid lice	collipation	CONTRALE	
	Deductible	Deductible	Deductible	Deductible	Deductible	50% Part A	75% Part A	50% Part A	Part A	
		Part B		Part B		Deductible	Deductible	Deductible	Deductible	
		Deductible		Deductible						
				Part B	Part B					
				EXCeSS (100%)	Excess (100%)					
		Forreign	Foreian	Foreign	Foreign			Foreign Travel	Foreign Travel	
		Travel Emergency	Travel Emergency	Travel Emergency	Travel Emergency Travel Emergency Travel Emergency Travel Emergency			Emergency	Emergency	
Plan F also has	an option	i called a high de	ductible Plan F.	This high ded	* Plan F also has an option called a high deductible Plan F. This high deductible plan pays	Out-of-Pocket	Out-of-Pocket			
ne same benefi nm hinh dedu	its as Plan F ctible Plan	the same benefits as Plan F after one has paid a calendar year \$2,070 deductible. Benef from high deductible Plan F will not begin until out-of-mocket expenses exceed \$2,070	aid a calendar) until out-of-no	/ear \$2,070 dei cket exnenses	the same benefits as Plan F after one has paid a calendar year \$2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-nocket expenses exceed \$2,070	Daid at 100%	nimit \$2330; paid at 100%			
ut-of-pocket e	xpenses fc	Out-of-pocket expenses for this deductible are expenses that would	e are expenses t	that would ord	ordinarily be paid by	after limit	after limit			

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.

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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; or (b) Your premium will increase each year because of the increase in your attained age. We, Forethought Life Insurance Company, can also coverage under Medicare changes.

There will be a one-time enrollment fee of \$25.00 added to the first premium.

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

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 If you find that you are not satisfied with your policy, you may return it to Forethought Life Insurance Company, P.O. Box 14659, Clearwater, 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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new Policy, be sure to answer truthfully and completely all questions about your medical and health history. 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.

- Monthly Premium Rates *	rting with: All
FORETHOUGHT LIFE INSURANCE COMPANY - M	These rates apply to ZIP codes starting with: All

Vonsmoker
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Plans -
Standard

	Female Plan F Plan G	Plan G		Plan N	Attained Age	Plan A	Plan C	<i>Male</i> Plan F	Plan G	Plan N
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\$186.01 \$300.85 \$260.97 \$219.28 \$222.70 \$188.04 \$305.40 \$264.92 \$223.70 \$222.70 \$190.09 \$309.98 \$268.88 \$225.13 \$223.64 \$190.09 \$314.43 \$273.1.80 \$279.17 \$223.4.96 \$195.62 \$321.80 \$279.11 \$233.4.96 \$233.4.96 \$197.22 \$323.83 \$279.11 \$234.96 \$234.96 \$197.22 \$332.84 \$228.64 \$233.03 \$234.96 \$197.81 \$333.68 \$220.19 \$234.92 \$234.07 \$201.98 \$334.80 \$229.19 \$246.32 \$246.32 \$201.98 \$334.80 \$229.19 \$246.32 \$246.37 \$201.98 \$334.80 \$236.45 \$246.26 \$226.37 \$201.98 \$334.80 \$236.19 \$256.37 \$267.46 \$201.48 \$356.19 \$256.37 \$256.37 \$252.36 \$201.87 \$234.16 \$2201.46 \$256.37 \$2246.23 <	\$221.35 \$185.91 \$164.94		\$164.94		77	\$182.06	\$293.30	\$254.43	\$213.69	\$189.59
\$188.04 \$305.40 \$264.92 \$222.70 \$223.00 \$190.09 \$3314.43 \$272.73 \$223.00 \$223.00 \$191.09 \$314.43 \$272.73 \$223.00 \$223.00 \$191.09 \$314.43 \$272.13 \$223.00 \$233.00 \$197.02 \$3231.80 \$279.11 \$234.06 \$234.07 \$197.22 \$335.86 \$220.19 \$234.07 \$233.03 \$197.22 \$335.86 \$220.19 \$234.07 \$234.07 \$201.98 \$3336.88 \$220.19 \$234.07 \$234.07 \$201.98 \$3336.88 \$220.19 \$234.07 \$234.07 \$201.98 \$334.076 \$234.02 \$246.32 \$246.32 \$201.91 \$234.107 \$234.02 \$246.32 \$246.32 \$201.91 \$334.076 \$234.02 \$255.36 \$246.32 \$201.08 \$334.076 \$256.44 \$256.44 \$256.44 \$201.08 \$334.09 \$256.44 \$2564.45 \$256.46 \$256.46	\$227.04 \$190.77 \$169.38		\$169.38		78	\$186.01	\$300.85	\$260.97	\$219.28	\$194.69
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\$197.22 \$325.86 \$228.64 \$238.03 \$ \$198.68 \$329.84 \$286.09 \$241.07 \$ \$201.98 \$336.88 \$2395.19 \$246.32 \$ \$201.98 \$336.88 \$2395.55 \$246.32 \$ \$203.33 \$340.76 \$295.55 \$\$249.29 \$ \$204.70 \$344.80 \$299.04 \$\$245.37 \$ \$205.33 \$344.80 \$302.46 \$\$255.37 \$ \$207.48 \$348.75 \$302.46 \$\$255.37 \$ \$207.48 \$5348.75 \$305.93 \$\$256.47 \$ \$207.48 \$5344.76 \$\$256.47 \$ \$ \$207.48 \$536.22 \$303.693 \$\$264.43 \$ \$ \$210.87 \$\$352.76 \$\$3305.93 \$\$264.46 \$ \$ \$ \$ \$210.87 \$\$360.22 \$\$333.71 \$\$274.41 \$ \$ \$ \$ \$ \$217.01 \$\$213.80 \$\$316.04	\$242.83 \$204.42 \$182.00		\$182.00		82	\$195.62	\$321.80	\$279.11	\$234.96	\$209.19
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\$203.33 \$340.76 \$295.55 \$249.29 \$ \$204.70 \$344.80 \$299.04 \$252.36 \$ \$205.08 \$348.75 \$302.46 \$255.37 \$ \$205.08 \$348.75 \$302.46 \$255.37 \$ \$207.48 \$352.75 \$302.46 \$255.37 \$ \$207.48 \$355.75 \$305.93 \$255.47 \$ \$210.87 \$356.43 \$305.46 \$256.47 \$ \$210.87 \$356.43 \$310.60 \$256.416 \$ \$211.33 \$364.43 \$3116.04 \$267.46 \$ \$211.345 \$368.80 \$3116.04 \$267.46 \$ \$211.01 \$378.01 \$319.82 \$274.41 \$ \$217.01 \$378.01 \$323.719 \$274.41 \$ \$221.64 \$3386.31 \$323.719 \$278.10 \$ \$222.17 \$334.99 \$278.10 \$ \$ \$222.17 \$336.31 \$323.710 \$	\$254.21 \$214.30 \$191.23		\$191.23		85	\$201.98	\$336.88	\$292.19	\$246.32	\$219.81
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\$223.56 \$395.58 \$343.01 \$291.74 \$224.92 \$400.17 \$346.99 \$295.36 \$226.30 \$404.89 \$351.07 \$299.09	\$295.02 \$250.71 \$225.64		\$225.64		96	\$222.17	\$391.06	\$339.10	\$288.17	\$259.36
\$224.92 \$400.17 \$346.99 \$295.36 \$226.30 \$404.89 \$351.07 \$299.09	\$298.42 \$253.81 \$228.61		\$228.61		97	\$223.56	\$395.58	\$343.01	\$291.74	\$262.77
\$226.30 \$404.89 \$351.07 \$299.09	\$301.88 \$256.96 \$231.65		\$231.65		98	\$224.92	\$400.17	\$346.99	\$295.36	\$266.26
	\$305.43 \$260.21 \$234.77		\$234.77		66	\$226.30	\$404.89	\$351.07	\$299.09	\$269.85

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

MSOC10-01-NJ

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- Monthly Premium Rates *
FORETHOUGHT LIFE INSURANCE COMPANY

These rates apply to ZIP codes starting with: All

Standard Plans - Smoker

NIA \$254.97 NIA NIA NIA \$162.93 \$254.97 \$221.20 \$185.18 \$5 \$162.93 \$254.97 \$221.20 \$185.18 \$5 \$162.93 \$254.97 \$221.20 \$185.18 \$5 \$162.93 \$254.97 \$221.20 \$185.18 \$5 \$162.93 \$256.38 \$221.20 \$185.18 \$5 \$162.93 \$256.38 \$228.04 \$233.18 \$5 \$5 \$173.46 \$270.04 \$236.07 \$191.62 \$5 \$5 \$183.06 \$288.54 \$226.22 \$520.71 \$5 \$5 \$191.4 \$310.08 \$2263.26 \$314.25 \$250.71 \$5 \$191.78 \$310.08 \$2563.76 \$252.05 \$5 \$5 \$191.78 \$310.08 \$256.38 \$228.60 \$5 \$5 \$191.78 \$230.06 \$252.05 \$25 \$5 \$5 \$191.78 \$310.08 \$256.32 \$250.07 <th>Female Ai Plan F Plan G</th> <th>Plan G Plan N</th> <th>Plan N</th> <th></th> <th>Attai Ag</th> <th>ned e</th> <th>Plan A</th> <th>Plan C</th> <th>Male Plan F</th> <th>Plan G</th> <th>Plan N</th>	Female Ai Plan F Plan G	Plan G Plan N	Plan N		Attai Ag	ned e	Plan A	Plan C	Male Plan F	Plan G	Plan N
66 \$162.93 \$254.97 \$221.20 \$185.18 6 6 \$162.93 \$254.97 \$221.20 \$185.18 6 6 \$162.93 \$254.97 \$221.20 \$185.18 6 6 \$168.27 \$228.497 \$228.10 \$191.20 \$186.17 6 \$173.46 \$226.44 \$228.50 \$191.20 \$191.20 7 \$188.10 \$2286.38 \$226.17 \$203.76 \$203.76 7 \$181.46 \$230.44 \$226.50 \$203.76 \$226.60 7 \$191.48 \$303.61 \$226.56 \$226.60 \$226.60 7 \$191.48 \$303.61 \$226.58 \$226.50 \$226.50 7 \$199.79 \$231.41 \$230.45 \$226.50 \$226.50 7 \$199.79 \$231.41 \$232.451 \$226.50 \$226.50 7 \$213.80 \$331.41 \$232.451 \$226.50 \$227.00 7 \$213.81 \$230.451 \$232.481 </th <th>\$221.82 N/A N/A N/A</th> <th></th> <th>N/A</th> <th></th> <th>N/A</th> <th><65</th> <th>N/A</th> <th>\$254.97</th> <th>N/A</th> <th>N/A</th> <th>N/A</th>	\$221.82 N/A N/A N/A		N/A		N/A	<65	N/A	\$254.97	N/A	N/A	N/A
06 \$162.03 \$224.97 \$221.20 \$185.18 0 1 66 \$162.03 \$254.97 \$221.20 \$185.18 0 1 66 \$163.03 \$254.97 \$223.00 \$197.62 \$197.62 1 70 \$178.39 \$280.44 \$2243.30 \$503.78 \$200.72 1 71 \$183.06 \$280.44 \$243.30 \$203.78 \$200.72 1 71 \$183.06 \$280.44 \$243.30 \$203.78 \$200.72 1 71 \$183.06 \$280.44 \$243.30 \$200.72 \$216.40 1 71 \$183.06 \$286.33 \$220.71 \$216.40 \$220.71 1 71 \$184.44 \$230.450 \$220.71 \$216.40 \$220.71 1 71 \$184.44 \$230.450 \$220.71 \$226.66 \$226.71 1 71 \$220.66.59 \$331.44 \$276.68 \$227.05 \$227.05 1 77	\$221.82 \$192.44 \$161.11 \$1	\$161.11		\$1	42.22	65	\$162.93	\$254.97	\$221.20	\$185.18	\$163.47
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68 \$168.27 \$235.36 \$191.29 \$191.29 70 \$173.46 \$273.04 \$233.713 \$197.62 71 \$183.06 \$280.44 \$230.32 \$297.72 71 \$183.06 \$288.04 \$257.07 \$215.45 71 \$183.06 \$288.04 \$257.07 \$215.45 72 \$194.89 \$310.17 \$282.20 \$215.45 73 \$194.89 \$330.46 \$257.07 \$220.71 74 \$199.79 \$319.17 \$202.20 \$215.60 75 \$199.79 \$337.13 \$202.20 \$220.71 77 \$200.59 \$337.13 \$202.20 \$215.60 77 \$202.65 \$337.13 \$202.20 \$225.05 78 \$216.14 \$337.13 \$229.20 \$255.05 79 \$218.10 \$323.14 \$226.05 \$225.05 70 \$232.22 \$233.13 \$223.26 \$226.05 80 \$216.14 \$336.14 \$230.1	\$192.44 \$161.11	\$161.11		\$142	2.22	67	\$162.93	\$254.97	\$221.20	\$185.18	\$163.47
69 \$173.46 \$272.04 \$236.01 \$197.62 70 \$178.39 \$280.44 \$230.378 \$203.78 71 \$181.306 \$288.54 \$250.32 \$200.72 73 \$191.44 \$330.46 \$285.107 \$215.45 73 \$191.44 \$330.46 \$268.99 \$225.60 75 \$199.79 \$319.17 \$251.61 \$225.60 75 \$199.49 \$310.17 \$252.60 \$221.37 76 \$2006.59 \$331.44 \$287.52 \$241.37 77 \$200.59 \$331.44 \$287.50 \$226.32 76 \$200.59 \$331.41 \$287.52 \$241.37 77 \$200.59 \$331.41 \$287.50 \$225.05 78 \$213.60 \$334.55 \$226.35 \$221.37 80 \$211.61 \$330.45 \$226.36 \$227.00 81 \$220.66 \$337.13 \$2265.98 \$2263.16 80 \$216.40 \$330.45 \$	\$198.80 \$166.42	\$166.42		\$14	6.92	68	\$168.27	\$263.38	\$228.50	\$191.29	\$168.87
70 \$176.30 \$280.44 \$243.30 \$203.78 71 \$183.06 \$288.54 \$257.07 \$203.78 72 \$181.46 \$2303.46 \$257.07 \$205.32 \$205.71 73 \$1191.44 \$3303.46 \$255.07 \$225.60 \$225.60 75 \$199.79 \$319.17 \$276.88 \$225.07 \$225.06 76 \$199.79 \$319.17 \$276.88 \$223.32 \$223.32 77 \$209.79 \$319.14 \$287.52 \$241.37 \$225.06 77 \$209.79 \$314.44 \$287.68 \$225.32 \$223.32 77 \$2208.56 \$337.13 \$228.45 \$224.35 \$224.36 77 \$220.45 \$330.46 \$233.71 \$226.92 \$227.07 81 \$220.51 \$331.44 \$330.46 \$227.05 \$228.37 82 \$228.37 \$300.50 \$228.37 \$227.07 \$228.37 81 \$228.37 \$330.46 \$237.09 \$228.3	\$205.33 \$171.93	\$171.93		\$15	51.82	69	\$173.46	\$272.04	\$236.01	\$197.62	\$174.51
71 \$183.06 \$288.54 \$250.32 \$200.72 \$200.72 72 \$187.46 \$206.33 \$257.07 \$215.45 \$200.72 73 \$191.44 \$503.36 \$220.71 \$201.32 \$220.71 74 \$194.89 \$310.08 \$268.39 \$223.32 \$203.32 75 \$194.89 \$310.44 \$530.526 \$224.37 \$223.32 77 \$209.26 \$337.13 \$224.55 \$241.37 \$225.66 77 \$209.26 \$337.13 \$222.45 \$225.66 \$241.37 78 \$216.14 \$351.04 \$304.60 \$255.92 \$241.37 79 \$216.14 \$337.13 \$222.48 \$227.00 \$256.66 80 \$221.66 \$337.13 \$227.00 \$256.66 \$277.00 81 \$222.66 \$337.13 \$223.48 \$277.00 \$277.00 82 \$223.37 \$339.17 \$236.65 \$283.10 \$277.00 82 \$223.61 \$337.45 </td <td>\$211.67 \$177.29</td> <td>\$177.29</td> <td></td> <td>\$</td> <td>56.63</td> <td>70</td> <td>\$178.39</td> <td>\$280.44</td> <td>\$243.30</td> <td>\$203.78</td> <td>\$180.03</td>	\$211.67 \$177.29	\$177.29		\$	56.63	70	\$178.39	\$280.44	\$243.30	\$203.78	\$180.03
72 \$187.48 \$296.33 \$257.07 \$215.45 73 \$1191.44 \$303.46 \$223.26 \$220.71 74 \$1191.44 \$303.46 \$223.26 \$223.23 75 \$119.19 \$319.17 \$286.99 \$223.23 7 \$219.89 \$311.41 \$281.55 \$241.37 7 \$206.59 \$337.13 \$224.52 \$243.37 7 \$2206.59 \$337.13 \$224.52 \$243.37 7 \$2206.59 \$337.13 \$224.63 \$243.37 7 \$2206.59 \$337.13 \$224.63 \$243.37 80 \$216.14 \$337.13 \$224.65 \$243.37 81 \$2216.69 \$337.13 \$239.46 \$253.06 81 \$222.66 \$337.13 \$313.48 \$227.00 82 \$223.31 \$337.455 \$237.84 \$277.00 82 \$222.66 \$337.455 \$237.66 \$277.00 82 \$222.66 \$337.455 \$23	\$217.78 \$182.46	\$182.46		\$	161.26	71	\$183.06	\$288.54	\$250.32	\$209.72	\$185.36
73 \$191.44 \$303.46 \$263.26 \$220.71 74 \$194.89 \$310.08 \$268.39 \$225.60 75 \$199.79 \$319.17 \$287.52 \$224.37 76 \$199.79 \$337.13 \$287.52 \$224.37 77 \$209.26 \$337.13 \$2292.45 \$255.98 77 \$209.26 \$337.13 \$2292.45 \$255.98 79 \$216.14 \$336.50 \$337.55 \$225.60 79 \$218.19 \$336.51 \$329.97 \$225.68 80 \$218.19 \$336.50 \$330.55 \$225.68 81 \$220.69 \$337.13 \$232.28 \$277.09 82 \$221.66 \$337.45 \$277.09 \$275.06 81 \$220.69 \$374.55 \$323.37 \$277.09 82 \$222.69 \$337.13 \$233.71 \$283.313 82 \$222.69 \$337.25 \$233.71 \$270.07 83 \$2224.85 \$337.45 \$23	\$223.65 \$187.44	\$187.44		\$	165.75	72	\$187.48	\$296.33	\$257.07	\$215.45	\$190.52
74 \$194.80 \$310.08 \$268.90 \$225.60 75 \$199.79 \$319.17 \$276.88 \$232.32 76 \$199.79 \$331.14 \$287.52 \$241.37 77 \$209.26 \$337.13 \$255.06 \$245.51 78 \$216.14 \$536.10 \$3304.50 \$255.95 80 \$216.14 \$536.104 \$3304.50 \$255.95 81 \$220.669 \$331.45 \$255.06 \$255.92 81 \$220.669 \$337.15 \$313.48 \$255.92 82 \$222.669 \$337.4.55 \$323.6.82 \$277.09 81 \$222.669 \$374.55 \$323.7.1 \$273.60 82 \$223.37 \$330.71 \$313.48 \$267.07 83 \$222.669 \$374.55 \$323.76 \$277.09 84 \$223.37 \$339.71 \$233.66 \$277.09 86 \$223.37 \$337.35 \$233.66 \$277.09 86 \$223.37 \$337.35	\$229.04 \$192.02	\$192.02		\$	169.88	73	\$191.44	\$303.46	\$263.26	\$220.71	\$195.27
75 \$199.79 \$319.17 \$276.88 \$237.32 7 76 \$206.59 \$331.44 \$287.52 \$241.37 7 7 \$209.26 \$331.43 \$287.52 \$241.37 7 \$209.26 \$331.44 \$287.52 \$241.37 \$252.06 7 \$209.26 \$331.41 \$299.97 \$255.96 \$245.60 80 \$216.14 \$351.04 \$304.50 \$255.96 \$253.76 81 \$220.68 \$351.41 \$304.50 \$255.96 \$277.07 82 \$224.85 \$369.88 \$323.28.4 \$277.00 \$256.376 82 \$223.51 \$374.55 \$332.84 \$277.00 \$277.00 83 \$223.56 \$337.13 \$335.86 \$277.00 \$277.00 84 \$223.51 \$334.45 \$233.51 \$277.00 \$277.00 86 \$233.71 \$337.45 \$323.66 \$277.00 \$273.66 86 \$233.71 \$337.45 \$333.71 <	\$234.02 \$196.27	\$196.27			3173.77	74	\$194.89	\$310.08	\$268.99	\$225.60	\$199.73
76 \$206.59 \$331.44 \$287.52 \$241.37 77 \$209.26 \$337.13 \$287.52 \$241.37 78 \$213.80 \$335.13 \$292.45 \$245.62 79 \$213.80 \$355.04 \$255.05 \$245.62 79 \$218.49 \$355.04 \$352.05 \$255.98 80 \$218.49 \$356.30 \$309.06 \$255.98 81 \$220.68 \$351.41 \$313.48 \$255.92 82 \$224.85 \$309.06 \$255.36 \$277.09 83 \$2224.85 \$337.13 \$328.48 \$277.09 86 \$2233.71 \$3387.22 \$333.71 \$286.54 87 \$223.371 \$3387.22 \$327.360 \$277.09 88 \$223.371 \$3387.22 \$323.487 \$277.09 86 \$233.71 \$3387.72 \$2290.67 \$277.09 88 \$223.84 \$337.05 \$236.56 \$297.09 88 \$233.71 \$338.77	\$277.68 \$240.89 \$202.12 \$	\$202.12		\$	179.06	75	\$199.79	\$319.17	\$276.88	\$232.32	\$205.82
17 \$209.26 \$337.13 \$229.45 \$245.62 78 \$213.80 \$3345.81 \$299.97 \$255.05 79 \$216.14 \$331.04 \$356.30 \$356.93 \$255.98 80 \$218.49 \$356.30 \$330.06 \$255.98 \$255.98 81 \$220.68 \$334.14 \$331.48 \$255.92 \$255.93 81 \$220.68 \$334.55 \$330.06 \$255.92 \$270.07 82 \$221.85 \$330.141 \$313.48 \$253.76 \$270.07 83 \$220.69 \$374.55 \$333.71 \$371.09 \$277.09 83 \$222.16 \$337.455 \$373.66 \$277.09 \$277.09 84 \$223.16 \$339.71 \$313.48 \$277.09 \$277.09 85 \$223.16 \$337.15 \$339.71 \$273.60 \$273.60 86 \$233.71 \$339.71 \$339.71 \$277.09 \$277.09 86 \$233.71 \$339.715 \$339.716 \$237.	\$288.35 \$250.14 \$209.99 \$	\$209.99		\$	186.17	76	\$206.59	\$331.44	\$287.52	\$241.37	\$213.99
78 \$213.80 \$345.81 \$299.97 \$252.05 \$ 79 \$216.14 \$334.50 \$304.50 \$255.98 \$ 80 \$216.14 \$351.04 \$304.50 \$255.98 \$ 81 \$220.68 \$361.41 \$313.48 \$255.92 \$ 81 \$220.68 \$361.41 \$313.48 \$255.92 \$ 82 \$224.85 \$330.16 \$ \$ \$ 82 \$222.69 \$374.55 \$ \$ \$ \$ 83 \$222.83.7 \$3370.13 \$ \$ \$ \$ \$ 84 \$222.85.7 \$ <td>\$293.30 \$254.43 \$213.69 \$</td> <td>\$213.69</td> <td></td> <td>\$</td> <td>189.59</td> <td>17</td> <td>\$209.26</td> <td>\$337.13</td> <td>\$292.45</td> <td>\$245.62</td> <td>\$217.92</td>	\$293.30 \$254.43 \$213.69 \$	\$213.69		\$	189.59	17	\$209.26	\$337.13	\$292.45	\$245.62	\$217.92
79 \$216.14 \$351.04 \$304.50 \$255.98 \$ 80 \$218.49 \$356.30 \$309.06 \$255.92 \$ 81 \$220.68 \$361.41 \$313.48 \$255.30 \$ \$ 81 \$220.68 \$361.41 \$313.48 \$255.30 \$ \$ \$ 82 \$224.65 \$324.87 \$326.30 \$ <td>\$300.85 \$260.97 \$219.28 \$</td> <td>\$219.28</td> <td></td> <td>Ś</td> <td>194.69</td> <td>78</td> <td>\$213.80</td> <td>\$345.81</td> <td>\$299.97</td> <td>\$252.05</td> <td>\$223.78</td>	\$300.85 \$260.97 \$219.28 \$	\$219.28		Ś	194.69	78	\$213.80	\$345.81	\$299.97	\$252.05	\$223.78
80 \$218.49 \$356.30 \$309.06 \$259.92 \$ 81 \$220.68 \$361.41 \$313.48 \$263.76 \$ 82 \$220.68 \$361.41 \$313.48 \$263.76 \$ 82 \$220.68 \$361.41 \$313.48 \$263.76 \$ \$ 82 \$220.68 \$359.16 \$3374.55 \$323.84 \$277.09 \$ 83 \$228.37 \$3379.13 \$ \$324.87 \$	\$305.40 \$264.92 \$222.70 \$1	\$222.70		\$	97.86	79	\$216.14	\$351.04	\$304.50	\$255.98	\$227.42
81 \$220.68 \$361.41 \$313.48 \$263.76 82 \$224.85 \$369.88 \$313.48 \$263.76 83 \$226.69 \$374.55 \$320.82 \$270.07 84 \$228.37 \$379.13 \$323.84 \$277.09 85 \$228.37 \$337.15 \$339.71 \$286.54 86 \$233.71 \$339.72 \$333.71 \$286.54 86 \$233.71 \$339.72 \$333.71 \$286.54 87 \$233.71 \$339.72 \$333.71 \$286.54 86 \$233.71 \$339.72 \$333.71 \$286.54 87 \$233.71 \$339.72 \$333.71 \$286.54 88 \$2235.29 \$339.71 \$286.54 \$297.09 88 \$233.71 \$339.71 \$286.54 \$297.09 88 \$233.71 \$339.71 \$286.54 \$297.09 89 \$234.66 \$334.76 \$299.07 \$299.07 80 \$233.72 \$341.05 \$337.0	\$309.98 \$268.88 \$226.13 \$	\$226.13		Ś	201.04	80	\$218.49	\$356.30	\$309.06	\$259.92	\$231.08
82 \$224.85 \$369.88 \$320.82 \$270.07 \$ 83 \$226.69 \$374.55 \$324.87 \$273.60 \$ 84 \$228.37 \$379.13 \$333.65 \$237.109 \$ \$ 85 \$223.16 \$337.22 \$339.71 \$286.54 \$ \$ \$ 86 \$233.71 \$391.68 \$333.71 \$339.71 \$ <	\$272.73 \$229.47	\$229.47		\$2	204.15	81	\$220.68	\$361.41	\$313.48	\$263.76	\$234.66
83 \$226.69 \$374.55 \$324.87 \$273.60 84 \$228.37 \$3379.13 \$328.84 \$277.09 85 \$228.37 \$337.16 \$335.85 \$283.13 86 \$223.371 \$339.72 \$335.85 \$283.13 86 \$233.71 \$339.63 \$333.71 \$286.54 87 \$233.71 \$339.63 \$233.65 \$283.13 86 \$233.71 \$339.63 \$233.65 \$286.54 87 \$526.87 \$339.72 \$286.54 \$270.09 87 \$235.29 \$339.72 \$233.51 \$228.65 88 \$2235.29 \$339.72 \$2290.07 \$290.07 88 \$2236.87 \$334.766 \$237.06 \$293.63 90 \$2245.30 \$414.05 \$347.66 \$293.63 91 \$244.06 \$414.05 \$357.71 \$311.36 92 \$243.49 \$367.61 \$311.36 \$305.65 93 \$2249.40 \$414.04 <td< td=""><td>\$279.11 \$234.96</td><td>\$234.96</td><td></td><td></td><td>\$209.19</td><td>82</td><td>\$224.85</td><td>\$369.88</td><td>\$320.82</td><td>\$270.07</td><td>\$240.45</td></td<>	\$279.11 \$234.96	\$234.96			\$209.19	82	\$224.85	\$369.88	\$320.82	\$270.07	\$240.45
84 \$228.37 \$379.13 \$328.84 \$277.09 85 \$233.71 \$337.22 \$335.85 \$233.13 86 \$233.71 \$3391.68 \$333.71 \$286.54 \$ 86 \$233.71 \$3391.68 \$333.77 \$\$286.54 \$ \$ 87 \$235.29 \$336.32 \$334.72 \$\$236.54 \$ \$ 87 \$\$235.29 \$\$334.72 \$\$343.72 \$\$286.54 \$ \$ 87 \$\$235.29 \$\$396.32 \$\$343.72 \$\$286.57 \$ \$ 88 \$\$235.29 \$\$343.72 \$\$343.72 \$\$293.53 \$ \$ 90 \$\$238.48 \$\$400.86 \$\$343.72 \$\$293.53 \$ \$ 91 \$\$244.06 \$\$414.05 \$\$357.61 \$\$313.63 \$ \$ 92 \$\$247.59 \$\$418.88 \$\$356.05 \$\$317.42 \$ 93 \$\$244.49 \$\$414.49 \$\$357.61 \$\$311.36 \$	\$282.64 \$238.03	\$238.03		÷	212.08	83	\$226.69	\$374.55	\$324.87	\$273.60	\$243.77
85 \$232.16 \$337.22 \$335.85 \$283.13 \$283.13 86 \$233.71 \$3391.68 \$333.71 \$286.54 \$280.07 87 \$235.29 \$3396.32 \$343.72 \$286.54 \$290.07 87 \$235.29 \$3396.32 \$343.72 \$286.54 \$290.07 88 \$235.87 \$3396.32 \$343.72 \$286.54 \$290.07 88 \$235.87 \$3396.32 \$343.72 \$286.54 \$290.07 88 \$235.87 \$400.86 \$343.72 \$293.53 \$290.07 90 \$238.48 \$440.66 \$3414.05 \$355.06 \$303.63 \$293.63 91 \$244.06 \$418.88 \$356.761 \$311.36 \$317.42 \$311.36 92 \$244.49 \$418.88 \$356.761 \$311.36 \$316.41 \$316.41 93 \$244.49 \$444.04 \$3367.61 \$311.36 \$316.61 \$311.36 94 \$249.49 \$444.04 \$336.77 \$319.65	\$241.07	\$241.07			\$214.95	84	\$228.37	\$379.13	\$328.84	\$277.09	\$247.07
86 \$233.71 \$3391.68 \$339.71 \$286.54 87 \$235.29 \$396.32 \$339.71 \$286.54 87 \$235.29 \$396.32 \$334.76 \$290.07 88 \$235.29 \$396.32 \$347.66 \$290.07 89 \$236.87 \$400.86 \$347.66 \$290.07 90 \$224.38 \$414.05 \$3551.64 \$297.09 91 \$2242.38 \$414.05 \$3551.64 \$303.63 91 \$2244.06 \$414.05 \$355.06 \$307.42 92 \$244.06 \$418.88 \$365.06 \$317.42 93 \$2245.80 \$423.49 \$365.76 \$317.36 93 \$2245.59 \$423.49 \$367.67 \$311.36 94 \$249.44 \$429.06 \$375.77 \$319.65 95 \$255.37 \$444.04 \$3389.77 \$319.65 96 \$255.37 \$449.49 \$338.77 \$331.23 97 \$256.97 \$449.49 <td< td=""><td>\$292.19 \$246.32</td><td>\$246.32</td><td></td><td></td><td>\$219.81</td><td>85</td><td>\$232.16</td><td>\$387.22</td><td>\$335.85</td><td>\$283.13</td><td>\$252.65</td></td<>	\$292.19 \$246.32	\$246.32			\$219.81	85	\$232.16	\$387.22	\$335.85	\$283.13	\$252.65
87 \$235.29 \$396.32 \$343.72 \$290.07 \$290.07 88 \$236.87 \$400.86 \$347.66 \$293.53 \$290.07 89 \$236.87 \$400.86 \$347.66 \$293.53 \$297.09 90 \$238.48 \$405.46 \$351.64 \$297.09 \$297.09 90 \$224.06 \$414.05 \$355.08 \$303.63 \$297.42 91 \$244.06 \$414.05 \$355.06 \$330.63 \$297.42 92 \$245.80 \$418.88 \$355.06 \$330.742 \$ 93 \$244.06 \$414.05 \$356.06 \$317.41 \$ 94 \$249.44 \$423.40 \$3372.08 \$315.41 \$ 95 \$255.37 \$444.04 \$3376.77 \$319.65 \$ 96 \$255.37 \$449.49 \$3389.77 \$331.23 \$ 97 \$256.97 \$3389.77 \$3331.23 \$ \$ 97 \$256.97 \$544.69 \$ \$<	\$340.76 \$295.55 \$249.29		\$249.29		\$222.62	86	\$233.71	\$391.68	\$339.71	\$286.54	\$255.88
88 \$236.87 \$400.86 \$347.66 \$293.53 \$ 89 \$238.48 \$405.46 \$351.64 \$297.09 \$ 90 \$243.38 \$414.05 \$3559.08 \$303.63 \$ 91 \$244.06 \$418.88 \$363.26 \$303.63 \$ 91 \$244.06 \$418.88 \$365.05 \$303.63 \$ 92 \$245.80 \$423.91 \$365.05 \$311.36 \$ 93 \$247.59 \$423.49 \$367.61 \$311.36 \$ 93 \$245.60 \$424.49 \$367.77 \$319.65 \$ 94 \$249.44 \$434.49 \$337.07 \$319.65 \$ 96 \$255.37 \$444.04 \$3389.77 \$331.23 \$ 96 \$255.37 \$449.49 \$338.77 \$333.123 \$ 97 \$256.97 \$338.77 \$333.123 \$ \$ 98 \$256.97 \$449.49 \$338.77 \$333.123 \$			\$252.36		\$225.54	87	\$235.29	\$396.32	\$343.72	\$290.07	\$259.24
89 \$238.48 \$405.46 \$351.64 \$297.09 90 \$242.38 \$414.05 \$3559.08 \$303.63 \$ 91 \$244.06 \$414.05 \$353.26 \$307.42 \$ 92 \$245.80 \$414.05 \$367.61 \$311.36 \$ 92 \$247.59 \$423.91 \$367.61 \$311.36 \$ 93 \$247.59 \$423.49 \$367.61 \$311.36 \$ 93 \$247.59 \$423.49 \$367.61 \$311.36 \$ 93 \$244.49 \$434.49 \$367.67 \$319.65 \$ 94 \$249.44 \$434.49 \$337.77 \$319.65 \$ 96 \$255.37 \$449.49 \$338.77 \$331.23 \$ 97 \$256.97 \$328.76 \$3334.27 \$ \$ 98 \$256.53 \$449.49 \$389.77 \$ \$ \$ 97 \$256.97 \$ \$ \$ \$ \$ <	\$302.46		\$255.37		\$228.40	88	\$236.87	\$400.86	\$347.66	\$293.53	\$262.53
90 \$242.38 \$414.05 \$359.08 \$303.63 \$ 91 \$244.06 \$418.88 \$367.61 \$307.42 \$ 92 \$244.06 \$418.88 \$367.61 \$317.42 \$ 93 \$247.59 \$423.91 \$367.61 \$311.36 \$ 93 \$247.59 \$423.90 \$357.61 \$311.36 \$ 93 \$247.59 \$424.49 \$372.08 \$315.41 \$ 94 \$249.44 \$434.49 \$376.77 \$319.65 \$ \$ 96 \$253.61 \$444.04 \$3385.05 \$3331.23 \$ \$ 97 \$256.97 \$449.49 \$3389.77 \$331.23 \$ \$ 98 \$255.53 \$449.49 \$338.76 \$	\$305.93		\$258.47		\$231.34	89	\$238.48	\$405.46	\$351.64	\$297.09	\$265.91
91 \$244.06 \$418.88 \$363.26 \$307.42 \$307.42 92 \$245.80 \$423.91 \$367.61 \$311.36 \$311.36 93 \$247.59 \$429.06 \$372.08 \$315.41 \$315.41 94 \$249.44 \$434.49 \$372.08 \$319.65 \$319.65 94 \$249.44 \$434.49 \$336.07 \$319.65 \$319.65 95 \$253.61 \$444.04 \$3385.05 \$339.77 \$3319.65 96 \$255.37 \$449.49 \$3389.77 \$331.23 \$339.77 97 \$256.97 \$449.49 \$338.77 \$3331.23 \$336.76 98 \$256.97 \$454.69 \$338.84 \$333.49 \$339.49 99 \$260.12 \$465.39 \$303.63 \$333.49 \$333.43	\$360.22 \$312.40 \$264.16		\$264.16		\$236.62	90	\$242.38	\$414.05	\$359.08	\$303.63	\$271.98
92 \$245.80 \$423.91 \$367.61 \$311.36 \$311.36 93 \$247.59 \$429.06 \$372.08 \$315.41 \$315.41 94 \$249.44 \$434.49 \$376.77 \$319.65 \$316.67 95 \$249.44 \$434.49 \$336.05 \$316.65 \$316.65 96 \$255.37 \$444.04 \$338.05 \$326.95 \$326.95 97 \$256.97 \$449.49 \$339.77 \$331.23 \$339.49 98 \$256.37 \$454.69 \$394.27 \$335.35.33 \$394.99 99 \$260.12 \$465.39 \$303.63 \$333.49 \$333.49	\$364.43 \$316.04 \$267.46		\$267.46		\$239.75	91	\$244.06	\$418.88	\$363.26	\$307.42	\$275.58
93 \$247,59 \$429,06 \$372.08 \$315,41 94 \$249.44 \$434,49 \$376,77 \$319.65 95 \$253.61 \$444,04 \$336.05 \$326.95 96 \$255.37 \$449,49 \$389.77 \$331.23 97 \$256.97 \$449,49 \$339.77 \$331.23 97 \$256.97 \$454,69 \$3394.27 \$331.23 98 \$256.53 \$455.97 \$3394.27 \$335.33 98 \$256.07 \$455.97 \$3394.27 \$335.33 99 \$256.12 \$465.39 \$309.84 \$339.49 99 \$260.12 \$465.39 \$403.53 \$343.78			\$270.88		\$243.02	92	\$245.80	\$423.91	\$367.61	\$311.36	\$279.33
94 \$249.44 \$434.49 \$376.77 \$319.65 95 \$253.61 \$444.04 \$385.05 \$326.95 \$326.95 96 \$255.37 \$449.49 \$389.77 \$331.23 \$331.23 97 \$255.37 \$445.49 \$389.77 \$331.23 \$331.23 97 \$256.97 \$454.69 \$3394.27 \$331.23 \$331.23 98 \$256.53 \$459.97 \$3398.84 \$339.49 \$335.33 99 \$260.12 \$465.39 \$403.53 \$343.78 \$343.78	\$323.71		\$274.41		\$246.37	93	\$247.59	\$429.06	\$372.08	\$315.41	\$283.18
95 \$253.61 \$444.04 \$385.05 \$326.95 \$32.05 96 \$255.37 \$449.49 \$339.77 \$331.23 \$331.23 97 \$256.97 \$454.69 \$339.27 \$335.33 \$335.33 98 \$256.97 \$454.69 \$339.27 \$335.33 \$335.33 98 \$256.07 \$455.697 \$5398.84 \$333.23 \$335.33 98 \$256.07 \$455.697 \$5398.84 \$333.33 \$335.33 99 \$260.12 \$465.39 \$403.53 \$343.78 \$333.78	\$378.01 \$327.79 \$278.10	\$278.10			\$249.89	94	\$249.44	\$434.49	\$376.77	\$319.65	\$287.23
96 \$255.37 \$449.49 \$389.77 \$331.23 \$331.23 97 \$256.97 \$454.69 \$394.27 \$335.33 \$335.33 98 \$256.97 \$459.97 \$398.84 \$335.33 \$335.33 98 \$256.07 \$459.97 \$398.84 \$333.49 \$335.33 99 \$260.12 \$465.39 \$403.53 \$343.78 \$343.78	\$386.31 \$334.99 \$284.45	\$284.45			\$255.80	95	\$253.61	\$444.04	\$385.05	\$326.95	\$294.02
97 \$256.97 \$454.69 \$394.27 \$335.33 \$ 98 \$258.53 \$459.97 \$398.84 \$339.49 \$ 99 \$260.12 \$465.39 \$403.53 \$343.78 \$	\$391.06 \$339.10 \$288.17		\$288.17		\$259.36	96	\$255.37	\$449.49	\$389.77	\$331.23	\$298.11
98 \$258.53 \$459.97 \$339.84 \$339.49 99 \$260.12 \$465.39 \$403.53 \$343.78	\$395.58 \$343.01 \$291.74		\$291.74		\$262.77	97	\$256.97	\$454.69	\$394.27	\$335.33	\$302.04
99 \$260.12 \$465.39 \$403.53 \$343.78	\$346.99		\$295.36		\$266.26	98	\$258.53	\$459.97	\$398.84	\$339.49	\$306.05
	\$404.89 \$351.07 \$299.09		\$299.09		\$269.85	66	\$260.12	\$465.39	\$403.53	\$343.78	\$310.17

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

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

* 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 \$1,156	\$0	\$1,156 (Part A Deductible)
61st thru 90th day	All but \$289 a day	\$289 a day	\$0
91st day and after:			
 While using 60 lifetime reserve days 	All but \$578 a day	\$578 a day	\$0
 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 \$144.50 a day	\$0	Up to \$144.50 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 copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

**NOTICE: When Your Medicare Part A hospital benefits are exhausted, the insurer stands in 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.

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

* Once You have been billed \$140 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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$140 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First 3 nints	\$0	All costs	\$0
Next \$140 of Medicare-approved amounts* Remainder of Medicare-annroved amounts	\$0 80%	\$0 20%	ຽງ ຊາ40 (Part B Deductible) ຣັກ
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	50 \$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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 80%	\$0 20%	\$140 (Part B Deductible) \$0
- Relialituel of Ivieucare-approved attiounce	00/00	20.70	D¢

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

HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days All			
	All but \$1,156	\$1,156 (Part A Deductible)	\$0
61st thru 90th day All	All but \$289 a day	\$289 a day	\$0
91st day and after:			
While using 60 lifetime reserve days	All but \$578 a day	\$578 a day	\$0
 Once lifetime reserve days are used: 			
- Additional 365 days	0	100% of Medicare Eligible Expenses	\$0**
- Beyond the additional 365 days \$0	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	All approved amounts	\$0	\$0
21st thru 100th day All	but \$144.50 a day	Up to \$144.50 a day	\$0
101st day and after \$0		\$0	All Costs
BLOOD			
First 3 pints \$0		3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, for including a doctor's certification of terminal ca	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

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

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

* Once You have been billed \$140 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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$140 (Part B Deducticble) Generally 20%	\$ 5
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$140 (Part B Deducticble) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES		\$0	\$0
	PARTS A & B		
HOME HEALTH CARE MEDICARE-APPROVED SERVICES • Medically necessary skilled care services and medical supplies • Durable medical equipment	100%	\$0	\$0
First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 80%	\$140 (Part B Deducticble) 20%	\$0 \$0
OTHER BI	BENEFITS – NOT COVERED BY MEDICARE	Y 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
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PLANF	MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD
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* 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 \$1,156	\$1,156 (Part A Deductible)	\$0
6 Ist thru 90th day 91st day and after:	All but \$289 a day	\$289 a day	05
 While using 60 lifetime reserve days Once lifetime received and the second se second second se	All but \$578 a day	\$578 a day	\$0
 Other incluric reserve usys are used. Additional 365 days Beyond the additional 365 days 	\$0 \$0	100% of Medicare Eligible Expenses \$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 21st thru 100th day 101st day and after	All approved amounts All but \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

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

* Once You have been billed \$140 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.	ed amounts for covered serv	ices (which are noted with a	n asterisk), Your Part B
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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$140 (Part B Deducticble) Generally 20%	\$
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0%	All costs \$140 (Part B Deducticble) 20%	\$0 \$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
 First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts 	\$0 80%	\$140 (Part B Deducticble) 20%	\$0 \$0
OTHER BE	R BENEFITS – NOT COVERED BY MEDICARE	/ 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

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

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PLAN G EDICARE (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.

HOSPITALIZATION*HOSPITALLZATION*Semiprivate nom and board, general nursingSemiprivate nom and board, general nursingFirst of daysFirst of daysFirst of daysAll but \$7,156S (1 thru 90th day)All but \$2,99 a dayS (1 thru 90th day)All but \$2,99 a dayS (1 thru 90th day)All but \$2,98 a dayS (2 thru 90th day)Blut \$2,94 a dayS (2 thru 90th day)Blut \$2,44 a day	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
All but \$1,156 S1,156 (Part A Deductible) All but \$289 a day \$578 a day All but \$578 a day \$578 a day So \$50 of Medicare Eligible Expenses So \$00% of Medicare Eligible Expenses All approved amounts \$0 All but \$144.50 a day \$0 So \$0 All approved amounts \$0 So \$0 All but \$144.50 a day So \$0 So \$0 All but very limited copayment/coinsurance All but very limited copayment/respite Care Medicare copayment/	HOSPITALIZATION*			
All but \$1,156 \$1,156 (Part A Deductible) All but \$289 a day \$289 a day All but \$578 a day \$289 a day \$2 \$289 a day \$2 \$1,156 (Part A Deductible) \$2 \$28 a day \$2 \$28 a day \$2 \$20 \$2 \$20 \$2 \$20 \$2 \$20 \$2 \$20 \$2 \$20 \$2 \$20 \$2 \$20 \$2 \$2 \$3 \$0 \$4 \$4 \$4 \$0 \$5 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	Semiprivate room and board, general nursing			
All but \$1,156 \$1,156 (Part A Deductible) All but \$229 a day \$289 a day All but \$578 a day \$289 a day \$0 \$578 a day \$0 \$578 a day \$0 \$578 a day \$0 \$578 a day \$0 \$50 \$0 \$00% of Medicare Eligible Expenses \$0 \$0 \$1 approved amounts \$0 \$0 \$1 but \$144.50 a day \$0 \$0	and miscellaneous services and supplies			
All but \$289 a day \$289 a day All but \$578 a day \$578 a day \$0 100% of Medicare Eligible Expenses \$0 100% of Medicare Eligible Expenses \$0 \$0 RE* 100% of Medicare Eligible Expenses All approved amounts \$0 All but \$144.50 a day \$0 \$0 \$0 All but \$144.50 a day \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	First 60 days	All but \$1,156	\$1,156 (Part A Deductible)	\$0
All but 5578 a day 5578 a day \$0 \$00% of Medicare Eligible Expenses \$0 \$00% of Medicare Eligible Expenses \$100% of Medicare Eligible Expenses \$0 Re* \$0 All approved amounts \$0 All but \$144.50 a day \$0 \$0 \$0 <tr< td=""><td>61st thru 90th day</td><td>All but \$289 a day</td><td>\$289 a day</td><td>\$0</td></tr<>	61st thru 90th day	All but \$289 a day	\$289 a day	\$0
All but \$578 a day 5578 a day \$0 \$0 ys \$0 facility 100% of Medicare Eligible Expenses Re* \$0 All approved amounts \$0 All but \$144.50 a day \$0 \$0	91st day and after:			
S0 bysection S0 50 T00% of Medicare Eligible Expenses 50 RE** 100% of Medicare Eligible Expenses 50 Rest facility All approved amounts All but \$144.50 a day 50 S0 \$0 S0 \$0 All but \$144.50 a day 50 S0 \$0 In 00% \$0 All but very limited copayment/coinsurance care \$0	 While using 60 lifetime reserve days 	All but \$578 a day	\$578 a day	\$0
50 bys 50 50 100% of Medicare Eligible Expenses R=xt 100% of Medicare Eligible Expenses Reast 50 All approved amounts 50 All but \$144.50 a day 50 S0 50 S0 3 pints I00% 3 pints All but very limited copayment/coinsurance Medicare copayment/ care care	 Once lifetime reserve days are used: 			
ys \$0 \$0 RE* Ke \$0 Reast facility All approved amounts \$0 All approved amounts \$0 Up to \$144.50 a day All but \$144.50 a day \$0 \$0 So \$0 \$0 I 00% \$0 \$0 I but very limited copayment/coinsurance Medicare copayment/ tor outpatient drugs and inpatient respite coinsurance care care	- Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
RE* least least kin approved amounts All approved amounts \$0 All but \$144.50 a day \$0 All but \$144.50 a day \$0 \$0 Up to \$144.50 a day \$0<	- Beyond the additional 365 days	\$0	\$0	All Costs
least facility All approved amounts All but \$144.50 a day \$0 \$0 \$0 100% All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	SKILLED NURSING FACILITY CARE*			
least facilitykill approved amounts50 50 Up to \$144.50 a day \$0All but \$144.50 a day \$030 50All but \$144.50 a day \$030 50\$0 \$03 pints \$0\$0 \$03 pints \$0All but very limited copayment/coinsurance careAedicare copayment/ coinsurance	You must meet Medicare's requirements,			
facility All approved amounts \$0 All but \$144.50 a day \$0 \$0 \$0 \$0 100% \$3 hut very limited copayment/coinsurance \$0 for outpatient drugs and inpatient respite coinsurance consument/ care \$0 helicare copayment/coinsurance \$0 helicare copayment/ coinsurance \$0 helicare copayment/ consurance \$0 helicare copayment/ consurance \$0 helicare copayment/ consurance \$0 helicare	including having been in a hospital for at least			
All approved amounts \$0 All but \$144.50 a day \$0 All but \$144.50 a day Up to \$144.50 a day \$0 \$0 \$0 \$0 \$0 \$0 \$100% \$0 All but very limited copayment/coinsurance Medicare copayment/ coinsurance hal for outpatient drugs and inpatient respite care coinsurance	3 days and entered a Medicare approved facility			
All approved amounts \$0 All but \$144.50 a day Up to \$144.50 a day \$0 Up to \$144.50 a day \$0 \$0 \$0 \$0 \$0 \$0 \$100% \$0 All but very limited copayment/coinsurance Medicare copayment/ hal but very limited copayment/coinsurance Medicare copayment/ care care	within 30 days after leaving the hospital.			
All but \$144.50 a day Up to \$144.50 a day \$0 \$0 \$0 \$0 \$100% 3 pints All but very limited copayment/coinsurance Medicare copayment/ for outpatient drugs and inpatient respite coinsurance	First 20 days	ß	\$0	\$0
\$0 \$0 \$0 3 pints 100% \$0 All but very limited copayment/coinsurance Medicare copayment/ coinsurance hal for outpatient drugs and inpatient respite care coinsurance	21st thru 100th day		Up to \$144.50 a day	\$0
\$0 3 pints 100% 3 pints All but very limited copayment/coinsurance Medicare copayment/ for outpatient drugs and inpatient respite coinsurance	101st day and after		\$0	All Costs
\$0 3 pints 100% \$0 All but very limited copayment/coinsurance Medicare copayment/ for outpatient drugs and inpatient respite coinsurance care coinsurance	BLOOD			
100% \$0 All but very limited copayment/coinsurance Medicare copayment/ nal for outpatient drugs and inpatient respite care care	First 3 pints	\$0	3 pints	\$0
All but very limited copayment/coinsurance Medicare copayment/ for outpatient drugs and inpatient respite coinsurance care	Additional amounts	100%	\$0	\$0
All but very limited copayment/coinsurance Medicare copayment/ for outpatient drugs and inpatient respite coinsurance care	HOSPICE CARE			
ng a doctor's certification of terminal for outpatient drugs and inpatient respite care	You must meet Medicare's requirements,	All but very limited copayment/coinsurance	Medicare copayment/	\$0
	including a doctor's certification of terminal	for outpatient drugs and inpatient respite	coinsurance	
	illness	care		

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

* Once You have been billed \$140 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 \$140 of Medicare-approved amounts*	\$0 Ganarally 8006	\$0 5000 vilesand	\$140 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$140 (Part B Deductible) \$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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts 	\$0 80%	\$0 20%	\$140 (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	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit 20% and amounts over the \$50,000	20% and amounts over the \$50,000
		of \$50,000	lifetime maximum

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* 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 sumplies			
First 60 days	All but \$1,156	\$1,156 (Part A Deductible)	\$0
61st thru 90th day	All but \$289 a day	\$289 a day	\$0
91st day and after:			
 While using 60 lifetime reserve days 	All but \$578 a day	\$578 a day	\$0
 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 \$144.50 a day	Up to \$144.50 a day	\$0
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements,	All but very limited copayment / coinsurance	Medicare copayment / coinsurance	\$0
including a doctor's certification of terminal	for outpatient drugs and inpatient respite		
illness	care		

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

* Once You have been billed \$140 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 OUT- PATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$140 of Medicare-approved amounts* 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 copayment 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.	\$140 (Part B Deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency 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 \$140 of Medicare-approved amounts*	\$0 \$0	All costs \$0	\$0 \$140 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

HOME HEALTH CARE MENICARE A RUBOWED SERVICES			
Medically necessary skilled care services and medical supplies	100%	ξU	¢Ο
Durable medical equipment			2
 First \$140 of Medicare-approved amounts* 	\$0	\$0	\$140 (Part B Deducticble)
- Remainder of Medicare-approved amounts	80%	20%	\$0
OTHER BENE	OTHER BENEFITS – NOT COVERED BY MEDICARE	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 20% and amounts over the \$50,000	20% and amounts over the \$50,000
		of \$50,000	lifetime maximum

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PLAN N

MSOC10-01	

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 Sections 4, 5 and 6 are 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, and Medicare Supplement/Select Initial Premium Receipt (MSREC-01) – The Initial Premium Receipt must be left with the applicant(s) and the full modal premium is required with all applications.

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

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

Premiums and policy fee

Utilize the Forethought[®] Freedom[™] 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
- A voided check needs to be submitted with the Application for EFT

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 1-855-808-0944

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 Producer)

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

APPLICANT				
Medicare Supplement Standard Plan				
Medicare Supplement Select Plan (not available in all states)				
Requested Effective Date	Mail Policy To 🗌 Insured 🗌 Agent			
Initial Premium Collected \$	Renewal Premium \$			
Renewal Premium Mode 🗌 Annual 🔲 Semi-Annual 🗌 Qu	arterly 🗌 Monthly EFT			
APPLICANT B				
Medicare Supplement Standard Plan				
Medicare Supplement Select Plan (not available in all states)				
Requested Effective Date	Mail Policy To 🗌 Insured 🗌 Agent			
Initial Premium Collected \$	Renewal Premium \$			
Renewal Premium Mode 🗌 Annual 🗌 Semi-Annual 🗌 Qu	arterly 🗌 Monthly EFT			
SECTION 1 - IF APPLYING FOR MEDICARE SUPPLEMENT IN ALL QUESTIONS COMPLETELY.	SURANCE AND/OR LIFE INSURANCE, PLEASE ANSWER			
APPLICANT				
Last Name First	M.I.			
Mailing Address				
Residential Address (if different from Mailing Address)				
City	State Zip			
AgeDate of BirthState of Birth	🗌 Male 🔲 Female			
Home Phone # () - E-Mail Add	dress			
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			
AgeDate of BirthState of Birth	🗌 Male 🔲 Female			
Home Phone # () - E-Mail Add	dress			
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			
MSAPC1000-01-NJ Page 1 d	of 7 ©2010 Forethough			
FOR AGENT USE ONLY: Application for:	dicare Supplement 🛛 🖵 Life Insurance			

SECTION 2 - IF APPLYING FOR MEDICARE SUPPLEMENT INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

1.	Have you received a copy of the Guide to Health I	nsurance for People with	APPLICANT	APPLICANT B
	Medicare and the Outline of Coverage?		🗌 Yes 🗌 No	🗌 Yes 🗌 No
	Best of Your Knowledge:			
1.	Are you covered under Medicare Part A: If "YES," Part A effective date?/ Applicant		🗌 Yes 🗌 No	🗌 Yes 🗌 No
2.	If "NO," what is your eligibility date?Applicant Are you covered under Medicare Part B? If "YES," date?/ Applicant Applicant B If "NO," indicate date you plan to enroll.		🗌 Yes 🗌 No	🗌 Yes 🗌 No
4.	Applicant Applicant B Did you turn age 65 in the last six months? Did you enroll in Medicare Part B in the last six mo If "YES," indicate your effective date.	/	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
If you	lost or are losing other health insurance coverage	and received a notice from y	our prior insurer	saying you were
	e for guaranteed issue of a Medicare Supplement Ins			
	policy or certificate, you may be guaranteed acce			
	e a copy of the notice from your prior insurer with y	your application. PLEASE ANSV	VER ALL QUESTIO	NS. Please mark
	or "NO" with an "X" to the questions below. N 3 - FOR YOUR PROTECTION, THE NATIONAL			
	VE ASK THE FOLLOWING QUESTIONS ABOUT IN			
To the	Best of Your Knowledge:		APPLICANT	APPLICANT B
1.	Are you applying during a guaranteed issue period	?	🗌 Yes 🗌 No	🗌 Yes 🗌 No
	(NOTE: If the answer above is "YES," please attac			
2.	Do you have another Medicare Supplement Insurar	nce policy or certificate in		
	force (Select or Standard)?		🗌 Yes 🗌 No	🗌 Yes 🗌 No
	(a) If "YES," please complete the following:			
APPLIC				
	of Company	Policy/Certificate Number		
Plan		Issue Date		
APPLIC		Deliny (Contificate Number		
	of Company	Policy/Certificate Number		
Plan		Issue Date		
	(D) IT "YES " AN VALLINTANA TA PARISCA VALLE CUPPANT			
		t Medicare supplement		
	policy/certificate with this policy?		🗌 Yes 🗌 No	🗌 Yes 🗌 No
	policy/certificate with this policy?(c) If "YES," indicate termination date	/	🗌 Yes 🗌 No	🗌 Yes 🗌 No
	policy/certificate with this policy? (c) If "YES," indicate termination date (d) If "YES," have you received a copy of the repla	nt Applicant B acement notice?		□ Yes □ No □ Yes □ No
include questio	policy/certificate with this policy? (c) If "YES," indicate termination date (d) If "YES," have you received a copy of the replan have had any other Medicare plan coverage as reference Medicare supplement, please complete question on #4.	nt Applicant B acement notice? erenced below, not to s (a-g) below. If not, skip to		
include questio	policy/certificate with this policy? (c) If "YES," indicate termination date (d) If "YES," have you received a copy of the replation have had any other Medicare plan coverage as reference and the second sec	nt Applicant B acement notice? erenced below, not to is (a-g) below. If not, skip to than original Medicare within age plan, or a Medicare HMO		
include questio	policy/certificate with this policy? (c) If "YES," indicate termination date Application (d) If "YES," have you received a copy of the replation have had any other Medicare plan coverage as reference and the second secon	nt Applicant B acement notice? erenced below, not to as (a-g) below. If not, skip to than original Medicare within age plan, or a Medicare HMO you are still covered under		
include questio	policy/certificate with this policy? (c) If "YES," indicate termination date Application (d) If "YES," have you received a copy of the replation have had any other Medicare plan coverage as reference and the second secon	nt Applicant B acement notice? erenced below, not to as (a-g) below. If not, skip to than original Medicare within age plan, or a Medicare HMO you are still covered under		
include questio	policy/certificate with this policy? (c) If "YES," indicate termination date (d) If "YES," have you received a copy of the replation have had any other Medicare plan coverage as reference and the second sec	/	☐ Yes ☐ No	

(b) If "YES," have you received a copy of the replace	ement notice?		
(c) Reason for termination/disenrollment?		Yes 🗌 No	📋 Yes 📋 No
Applicant (d) Planned date of termination/disenrollment?	Applicant B	🗌 Yes 🗌 No	🗌 Yes 🗌 No
Applicant	Applicant B		
(e) Was this your first time in this type of Medicare p	lan?	🗌 Yes 🗌 No	🗌 Yes 🗌 No
(f) Did you drop a Medicare supplement or Medicare			
enroll in this Medicare plan? (g) Is your former Medicare supplement or Medicare	Select policy/certificate	Yes No	🗌 Yes 🗌 No
still available?		🗌 Yes 🗌 No	🗌 Yes 🗌 No
 Have you had coverage under any other health insura days? (For example, an employer, union, or individual 		🗌 Yes 🗌 No	🗌 Yes 🗌 No
plan.) (a) If "YES," with what company and what kind of po	licy/certificate?(list below)		
APPLICANT	(ist below)		
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 ar		der this plan,
leave "END" blank. START END Applicant	/ START Applican		
(c) Reason for termination/disenrollment?	1		
Applicant	Арр	olicant B	
(d) Planned date of termination/disenrollment?			
(d) Planned date of termination/disenrollment?	1		
Applicant	/Арр	licant B	
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N	tate Medicaid program? Spend-Down Program" and	Dlicant B	Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medica	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy?		Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medica (b) Do you receive any benefits from Medicaid OTHEL your Medicare Part B premium?	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward	Yes No	
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medica (b) Do you receive any benefits from Medicaid OTHEI your Medicare Part B premium? 6. Producers shall list any other health insurance policie	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward	Yes No Yes No Yes No	Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medica (b) Do you receive any benefits from Medicaid OTHEL your Medicare Part B premium?	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward es/certificates they have	Yes No Yes No Yes No	Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medica (b) Do you receive any benefits from Medicaid OTHEL your Medicare Part B premium? 6. Producers shall list any other health insurance policie sold to the applicant.	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward es/certificates they have	Yes No Yes No Yes No	Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medica (b) Do you receive any benefits from Medicaid OTHEL your Medicare Part B premium? 6. Producers shall list any other health insurance policie sold to the applicant. (a) List policies/certificates sold which are still in fo	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward es/certificates they have	Yes No Yes No Yes No	Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N If "YES,"	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward es/certificates they have rce. Policy/Certificate # Effective Date of Coverage	Yes No Yes No Yes No	Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "shave not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medica (b) Do you receive any benefits from Medicaid OTHEL your Medicare Part B premium? 6. Producers shall list any other health insurance policie sold to the applicant.	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward es/certificates they have rce. Policy/Certificate # Effective Date of Coverage ch are no longer in force:	Yes No Yes No Yes No	Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medica (b) Do you receive any benefits from Medicaid OTHEL your Medicare Part B premium? 6. Producers shall list any other health insurance policie sold to the applicant.	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward es/certificates they have rce. Policy/Certificate # Effective Date of Coverage ch are no longer in force: Policy/Certificate #	Yes No Yes No Yes No	Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "shave not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medica (b) Do you receive any benefits from Medicaid OTHEL your Medicare Part B premium? 6. Producers shall list any other health insurance policie sold to the applicant.	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward es/certificates they have rce. Policy/Certificate # Effective Date of Coverage ch are no longer in force:	Yes No Yes No Yes No	Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medica (b) Do you receive any benefits from Medicaid OTHEL your Medicare Part B premium? 6. Producers shall list any other health insurance policie sold to the applicant.	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward es/certificates they have rce. Policy/Certificate # Effective Date of Coverage ch are no longer in force: Policy/Certificate #	Yes No Yes No Yes No	Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medica (b) Do you receive any benefits from Medicaid OTHEL your Medicare Part B premium? 6. Producers shall list any other health insurance policie sold to the applicant.	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward es/certificates they have rce. Policy/Certificate # Effective Date of Coverage ch are no longer in force: Policy/Certificate #	Yes No Yes No Yes No	Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medicai (b) Do you receive any benefits from Medicaid OTHEL your Medicare Part B premium? 6. Producers shall list any other health insurance policie sold to the applicant.	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward es/certificates they have rce. Policy/Certificate # Effective Date of Coverage ch are no longer in force: Policy/Certificate # Effective Date of Coverage Policy/Certificate # Effective Date of Coverage	Yes No Yes No Yes No	Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medica (b) Do you receive any benefits from Medicaid OTHEL your Medicare Part B premium? 6. Producers shall list any other health insurance policie sold to the applicant.	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward es/certificates they have es/certificates they have rce. Policy/Certificate # Effective Date of Coverage ch are no longer in force: Policy/Certificate # Effective Date of Coverage Policy/Certificate # Effective Date of Coverage	Yes No Yes No Yes No	Yes No
Applicant 5. Are you covered for medical assistance through the s (NOTE TO APPLICANT: If you are participating in a "S have not met your "Share of Cost," please answer "N If "YES," (a) Will Medicaid pay your premiums for this Medicai (b) Do you receive any benefits from Medicaid OTHEL your Medicare Part B premium? 6. Producers shall list any other health insurance policies sold to the applicant.	tate Medicaid program? Spend-Down Program" and IO" to this question.) re supplement policy? R THAN payment toward es/certificates they have rce. Policy/Certificate # Effective Date of Coverage ch are no longer in force: Policy/Certificate # Effective Date of Coverage Policy/Certificate # Effective Date of Coverage	Yes No Yes No Yes No	Yes No

SECTION 4

IF APPLYING FOR ONLY MEDICARE SUPPLEMENT INSURANCE:

- During Open Enrollment or a Guaranteed Issue period, <u>SKIP SECTION 4 and GO TO SECTION 5.</u>
- 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.

of the following questions 1-14, that person is not eligible	for medicare supple				
To the Best of Your Knowledge:		APPLICANT	APPLICANT B		
you bedridden or confined to a wheelchair?					
2. Have you been diagnosed with emphysema, Chronic Pulmonary Disease (COPD) or other chronic pulmona		🗌 Yes 🗌 No	🗌 Yes 🗌 No		
 Have you been diagnosed with Parkinson's Disease, S Myasthenia Gravis, Multiple or Lateral Sclerosis, Oster 					
fractures, Cirrhosis or kidney disease requiring dialy 4. Have you been diagnosed with Alzheimer's Disease,		🗌 Yes 🗌 No	🗌 Yes 🗌 No		
any other cognitive disorder?					
Deficiency Syndrome (AIDS), AIDS Related Complex (🗌 Yes 🗌 No	🗌 Yes 🗌 No			
, , ,	Immunodeficiency Virus (HIV)? 6. If you have diabetes, do you have any of the following conditions:				
diabetic retinopathy, peripheral vascular disease, ne condition (including high blood pressure) or kidney d have diabetes, this question should be answered "NO	🗌 Yes 🗌 No	🗌 Yes 🗌 No			
Do you have diabetes that has ever required more th insulin daily?		🗌 Yes 🗌 No	🗌 Yes 🗌 No		
 Within the past two years have you been treated for a physician to have treatment for internal cancer, al abuse, mental or nervous disorder requiring psychiat 	🗌 Yes 🗌 No	🗌 Yes 🗌 No			
 had any amputation caused by disease? 9. Within the past two years have you been treated for a physician to have treatment for heart attack, hear 	🗌 Yes 🗌 No				
carotid artery disease (not including high blood press vascular disease, congestive heart failure or enlarge transient ischemic attacks (TIA) or heart rhythm disc 10. Within the past two years have you been treated for	🗌 Yes 🗌 No	🗌 Yes 🗌 No			
disease, crippling/disabling or rheumatoid arthritis c advised to have a joint replacement?		🗌 Yes 🗌 No	🗌 Yes 🗌 No		
11. Have you been advised by a physician that surgery m within the next 12 months for cataracts?	ay be required	🗌 Yes 🗌 No	🗌 Yes 🗌 No		
12. Have you been advised by a physician to have surger treatment or therapy that has not been performed?	y, medical tests,	🗌 Yes 🗌 No	🗌 Yes 🗌 No		
13. Have you been hospital confined three or more time years?		🗌 Yes 🗌 No	🗌 Yes 🗌 No		
14. Have you had an organ transplant or been advised by an organ transplant?		🗌 Yes 🗌 No	🗌 Yes 🗌 No		
15. Are you taking or have you taken any prescription or medications within the past 12 months? If "YES," ple and the condition in the following table.		🗌 Yes 🗌 No	🗌 Yes 🗌 No		
APPLICANT (attach a separate sheet if needed)					
Medication Name (pharmacy label)	Date Originally Pres	scribed			
Frequency and Dosage	Diagnosis/Condition				
APPLICANT B (attach a separate sheet if needed)	1				
Medication Name (pharmacy label)	Date Originally Pres	cribed			
Frequency and Dosage	Diagnosis/Condition				

SECTION 5 - IF APPLYING FOR 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 Life Insurance, you MUST answer all the questions in SECTION 4 of the application.

APPLICANT							
		Relation Applican			00 🗌 \$7,	,500 🗌 \$10,000	
						m Loan <i>- if available</i>	
Life Insurance Premium remitted with application Premium Mode:			∐ An	nnual 🗌 Quarte	Semi-Ann [ual Monthly EFT	
APPLICANT B (if applying for	or coverage)						
Beneficiary Name		Relation Applican	•	Othe	00 🗌 \$7, er	,500 🗌 \$10,000 	
Life Insurance Premium re S	mitted with appli	cation	Premium Mode:		nual	🗌 Semi-Ann	
SECTION 6 - REPLACEME	NT		<u> </u>				
 Are there any existing life insurance policies on the life of the applicant? 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. 							
SECTION 7 - BILLING INF	ORMATION						
A. ELECTRONIC FUNDS	TRANSFER (EFT)						
Checking	Account #						
Savings	ABA Routing/Tra	nsit Numb	per				
Standard Date (approxi			date of coverage)				
When processing is not cor following month to keep yo premium payment.							
Name and Telephone Num	ber of Financial Ir	stitution			Social S	ecurity Number of	Account Holder
B. INITIAL CREDIT CARD	PAYMENT - (Initi	al Premiu	m can be made on	credit car	rd; this is r	not available for Rer	newal Premiums)
Account # Ep. Dte BIE							
Cardholder Name							
C. AUTOMATIC PAYMEN	T AUTHORIZATIO	N - (Must L	be completed for l	EFT)			
l authorize Forethought Lin account. This authorizatio Forethought.							
Payor's Signature (As it app	pears on the bank ac	count)			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 multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

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

By this application I am applying to Forethought for:

 \Box 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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signed this Dav	-		City	, State	APPLICANT S	
Day	MOIL	ii feal	City	State	AFFLICANT 3	IGNATURE
Signed this	day of	_, in		,		
Day		h Year	City	State	APPLICANT B	SIGNATURE (if applicable)
AGENT ONLY SE	CTION - PREM	IUM MUST ACCO	OMPANY APPL	ICATION		
I certify that during an interview with the applicant(s) I have truly and accurately recorded in the application the						
information supp	olied by the ap	plicant(s).				
Do you have any	knowledge or	reason to believ	/e that this a	oplication replace	s existing life i	insurance? 🗌 Yes 🗌 No
Producer's Name	e (PRINT)	Producer	Number	Telepho	one Number	Producer's Signature

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

Agent Certification

FORE THOUGHT®

I the undersigned insurance agent certify;

THAT, I have taken an application for:

<u>Primary insured:</u> Medicare Supplement Standard	Medicare Supplement Select	<u>Applicant B:</u> Medicare Supplement Standard	Medicare Supplement Select
 Plan A Plan C Plan F Plan G Plan N 	□ Plan C □ Plan F □ Plan G □ Plan N	 Plan A Plan C Plan F Plan G Plan N 	 Plan C Plan F Plan G 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 - NOT AVAILABLE 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	
l, 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	

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 Medical Information Bureau, Inc. (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		

Calculate your premium

Medicare Supplement Plan

Before you begin: If you're not in your open enrollment or guarantee issue period, please see 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 pay- ment 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® FREEDOMSM

For total face amounts other than \$2, column by the number of units applic calculation.	Applicant's premium calculation	Applicant B's premium calculation		
Choose the base face amount of life insurance coverage you want to purchase (\$2,500, \$5,000, \$7,500 or \$10,000)	Base face amount \$5,000 (Example based on Male age 75 non-smoker)	Premium amount \$49.22		
Add any additional \$1,000 Face Amount increments	1 Additional \$1,000 increment x \$9.17 per \$1,000	Total additional increment premium = \$9.17		
Payment OptionsMultiply monthly premium by:3.01 for a quarterly premium5.95 for a semi-annual premium11.56 for an annual premiumBILLING MODE MUST BE THESAME AS THE MEDICARESUPPLEMENT BILLING MODE	\$49.22 base premium + \$9.17 additional increment \$58.39 total monthly premium for life insurance x3.01 (Quarterly) = \$175.75 x5.95 (Semi-annual)=\$347.42 x11.56 (Annual) = \$674.99	Total life premium \$49.22 <u>+ \$9.17</u> \$58.39		
Add the Medicare Supplement (from top section) and Life Insurance premiums (this section) together	\$153.52 (Med Supp) + \$58.39 (Life Ins) \$211.91	One check payable to Forethought Life Insurance Company for \$211.91		

COMPLETE AND RETURN WITH APPLICATION

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FORE THOUGHT®

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

- Minimum face amount \$2,500
- Maximum face amount \$25,000 Level death benefit \$15,000 Graded death benefit \$10,000 Return of premium death benefit
- Policy is rated on age at last birthday may backdate 6 months to save age.
- 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 Forethought Freedom 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+
Level benefit	100% of face	100% of face	100% of face
Graded benefit* (Accidental Death - 100% of face)	30% of face	70% of face	100% of face
Return of premium benefit*	110% premiums paid	110% premiums paid	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.

FORETHOUGHT[®] FREEDOM[™] LIFE INSURANCE

Monthly rates

					Fer	nale				
Issue	Per \$	1,000	\$2,	500	\$5,	000	\$7,	500	\$10	,000
Age	NS	S	NS	S	NS	S	NS	S	NS	S
65	\$3.89	\$5.54	\$13.10	\$17.21	\$22.84	\$31.05	\$32.57	\$44.89	\$42.30	\$58.73
66	\$4.07	\$5.80	\$13.54	\$17.86	\$23.70	\$32.35	\$33.86	\$46.84	\$44.03	\$61.33
67	\$4.24	\$6.06	\$13.97	\$18.51	\$24.57	\$33.65	\$35.16	\$48.79	\$45.76	\$63.92
68	\$4.41	\$6.31	\$14.40	\$19.16	\$25.43	\$34.95	\$36.46	\$50.73	\$47.49	\$66.52
69	\$4.67	\$6.66	\$15.05	\$20.02	\$26.73	\$36.68	\$38.41	\$53.33	\$50.08	\$69.98
70	\$4.93	\$7.01	\$15.70	\$20.89	\$28.03	\$38.41	\$40.35	\$55.92	\$52.68	\$73.44
71	\$5.28	\$7.53	\$16.56	\$22.19	\$29.76	\$41.00	\$42.95	\$59.81	\$56.14	\$78.63
72	\$5.62	\$8.04	\$17.43	\$23.48	\$31.49	\$43.60	\$45.54	\$63.71	\$59.60	\$83.82
73	\$5.97	\$8.56	\$18.29	\$24.78	\$33.22	\$46.19	\$48.14	\$67.60	\$63.06	\$89.01
74	\$6.31	\$9.08	\$19.16	\$26.08	\$34.95	\$48.79	\$50.73	\$71.49	\$66.52	\$94.20
75	\$6.75	\$9.60	\$20.24	\$27.38	\$37.11	\$51.38	\$53.98	\$75.38	\$70.84	\$99.39
76	\$7.61	\$10.73	\$22.40	\$30.19	\$41.43	\$57.00	\$60.46	\$83.82	\$79.49	\$110.63
77	\$8.48	\$11.85	\$24.57	\$33.00	\$45.76	\$62.63	\$66.95	\$92.25	\$88.14	\$121.88
78	\$9.34	\$12.98	\$26.73	\$35.81	\$50.08	\$68.25	\$73.44	\$100.69	\$96.79	\$133.12
79	\$10.21	\$14.19	\$28.89	\$38.84	\$54.41	\$74.30	\$79.93	\$109.77	\$105.44	\$145.23
80	\$11.07	\$15.40	\$31.05	\$41.87	\$58.73	\$80.36	\$86.41	\$118.85	\$114.09	\$157.34

Monthly EFT premium rates - full death benefit coverage only

	Male										
Issue	Per \$	1,000	\$2,	500	\$5,	000	\$7,500 \$1		\$10	0,000	
Age	NS	S	NS	S	NS	S	NS	S	NS	S	
65	\$4.93	\$7.27	\$15.70	\$21.54	\$28.03	\$39.70	\$40.35	\$57.87	\$52.68	\$76.03	
66	\$5.28	\$7.79	\$16.56	\$22.84	\$29.76	\$42.30	\$42.95	\$61.76	\$56.14	\$81.22	
67	\$5.62	\$8.39	\$17.43	\$24.35	\$31.49	\$45.33	\$45.54	\$66.30	\$59.60	\$87.28	
68	\$5.97	\$9.00	\$18.29	\$25.86	\$33.22	\$48.35	\$48.14	\$70.84	\$63.06	\$93.33	
69	\$6.31	\$9.60	\$19.16	\$27.38	\$34.95	\$51.38	\$50.73	\$75.38	\$66.52	\$99.39	
70	\$6.66	\$10.21	\$20.02	\$28.89	\$36.68	\$54.41	\$53.33	\$79.93	\$69.98	\$105.44	
71	\$7.09	\$10.99	\$21.11	\$30.84	\$38.84	\$58.30	\$56.57	\$85.76	\$74.30	\$113.23	
72	\$7.53	\$11.76	\$22.19	\$32.78	\$41.00	\$62.19	\$59.81	\$91.60	\$78.63	\$121.01	
73	\$8.04	\$12.54	\$23.48	\$34.73	\$43.60	\$66.09	\$63.71	\$97.44	\$83.82	\$128.80	
74	\$8.56	\$13.49	\$24.78	\$37.11	\$46.19	\$70.84	\$67.60	\$104.58	\$89.01	\$138.31	
75	\$9.17	\$14.45	\$26.30	\$39.49	\$49.22	\$75.60	\$72.14	\$111.71	\$95.06	\$147.83	
76	\$10.47	\$16.18	\$29.54	\$43.81	\$55.71	\$84.25	\$81.87	\$124.69	\$108.04	\$165.13	
77	\$11.76	\$17.91	\$32.78	\$48.14	\$62.19	\$92.90	\$91.60	\$137.66	\$121.01	\$182.43	
78	\$13.06	\$19.64	\$36.03	\$52.46	\$68.68	\$101.55	\$101.33	\$150.64	\$133.99	\$199.73	
79	\$14.36	\$21.37	\$39.27	\$56.79	\$75.17	\$110.20	\$111.07	\$163.61	\$146.96	\$217.03	
80	\$15.74	\$23.10	\$42.73	\$61.11	\$82.09	\$118.85	\$121.45	\$176.59	\$160.80	\$234.33	

To estimate the monthly premium for face amounts other than \$2,500, \$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

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

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

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

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration and acceptance by the replacing insurer, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT

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

Additional benefits.

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

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

2. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for any company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

Signature of Agent, Broker, or other Representative

PRINTED Name and Address of Issuer, Agent, or Broker

Applicant's Signature

Signature of Applicant B, if applying

Date

MSRN10-01

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

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

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You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration and acceptance by the replacing insurer, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT

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

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

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

2. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for any company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

Signature of Agent, Broker, or other Representative

PRINTED Name and Address of Issuer, Agent, or Broker

Applicant's Signature

Signature of Applicant B, if applying

Date

HUR THÔUGH

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.

- Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning 1. to the insurer, or otherwise terminating your existing policy or contract? Q YES Q NO
- Are you considering using funds from your existing policies or contracts to pay premiums due on 2. the new policy or contract? **Q** YES

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	CONTRACT OR	INSURED OR	REPLACED (R) OR
NAME & ADDRESS	POLICY #	ANNUITANT	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

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

Date

FORE THOUGHT

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? **Q** YES
- 2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? **U**YES

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	CONTRACT OR	INSURED OR	REPLACED (R) OR
NAME & ADDRESS	POLICY #	ANNUITANT	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.)

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

INVESTIGATIVE CONSUMER REPORT NOTICE TO APPLICANT

Federal law requires that notice of investigation be given to persons applying for insurance. In making this application for insurance to Forethought Life Insurance Company (the Company), it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living (the term "mode of living" does not relate directly or indirectly to the sexual orientation of any proposed insured). You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon proper identification, you have the right to inspect and/or receive a copy of the report from the consumer reporting agency. You have the right to make a written request to the Company within a reasonable period of time to receive additional detailed information about the nature and scope of the investigation. Write to: Underwriting Department, Forethought Life Insurance Company, P.O. Box14659, 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 it's reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB 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 <u>www.mib.com</u>.

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

Forethought Life Insurance Company

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

Follow these easy steps to submit Medicare Supplement / 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 will need to 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 1-855-808-0944

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

3) Voided Check for EFT

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

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



Forethought Life Insurance Company

FAX TRANSMITTAL

FOR USE WITH EFT MONTHLY PREMIUM APPLICATIONS ONLY

<u>1-855-808-0944</u>

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

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

MSCFAX01-02

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Forethought Life Insurance Company ("Forethought"), provides innovative insurance and financial solutions for families managing retirement and end-of-life needs. Headquartered in Indianapolis, Indiana, Forethought provides life insurance and annuities.

Forethought has been consistently recognized by A.M. Best for financial strength.

As of June 30, 2011, Forethought has assets owned and under management in excess of \$5.1 billion, approximately \$1 billion in annual revenue, more than \$4.6 billion of life insurance and annuity business in force, and has served more than 2 million policyholders since 1985.

Forethought Life Insurance Company

Administrative office PO Box 14659 Clearwater, FL 33766-4659

Phone: 1-877-492-5870

www.forethought.com

