2011 SELECT Medicare Supplement/ Life Insurance Plans

Issued by Forethought Life Insurance Company

THINKING AHEAD℠

FORETHOUGHT®

SS3000-01
LA 1011

2011 Forethought® Select Medicare Supplement Insurance Plans

You can rely on Forethought® Select 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:

- Four 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 Select Medicare Supplement insurance is underwritten by:

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

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

Choose the Forethought® plan that best fits your needs!

	MEDICARE PAYS	SELECT PLAN C PAYS	SELECT PLAN F PAYS	SELECT PLAN G PAYS	SELECT PLAN N PAYS
***Medicare Part A* hospital coverage**					
Deductible		$1,132*	$1,132*	$1,132*	$1,132*
First 60 days	100%				
Coinsurance 61–90 days	All but $283 a day	$283 a day	$283 a day	$283 a day	$283 a day
Coinsurance 91–150 days (Lifetime Reserve)	All but $566 a day	$566 a day	$566 a day	$566 a day	$566 a day
Extended hospital coverage (up to an additional 365 days in your lifetime)		Eligible expenses	Eligible expenses	Eligible expenses	Eligible expenses
Benefit for blood	All but 3 pints	3 pints	3 pints	3 pints	3 pints
Hospice care					
	All but limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance
Skilled nursing facility care					
First 20 days	100%				
Coinsurance 21–100 days	All but $141.50 a day	Up to $141.50 a day	Up to $141.50 a day	Up to $141.50 a day	Up to $141.50 a day
***Medicare Part B* physician's services and supplies**					
Deductible		$162	$162		
Coinsurance	Generally 80%	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
Other benefits**					
Emergency care received outside the USA		80% to lifetime max of $50,000	80% to lifetime max of $50,000	80% to lifetime max of $50,000	80% to lifetime max of $50,000
		Your premium	**Your premium**	**Your premium**	**Your premium**
		$ _____	**$** _____	**$** _____	**$** _____

*Your Medicare Select plan pays the Medicare Part A inpatient deductible when you use a network hospital (or if you use a non-network hospital for emergency care). Otherwise, you pay the inpatient deductible.
**Refer to the Outline of Coverage for more information.

† Subject to copayment for office and emergency room visits.

Your Select Plan care benefits

Medicare Part A hospital coverage

Deductible – When you use a network hospital, the $1,132 inpatient hospital deductible for each benefit period is waived. If you choose a non-network hospital, you are responsible for the Medicare Part A deductible. Of course, if you need emergency care, you may go to any hospital and the deductible will be waived.

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 – Select Plans C, F, G and N pay $283 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 Select Plans pay $566 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, Select Plans C, F, G and N pay the Part A Medicare eligible expenses for hospitalization, paid at the same rate Medicare would have paid had Medicare Part A hospital days not been exhausted, 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. Select Plans C, F, G and N pay the deductible.

Skilled nursing facility care – Medicare pays all eligible expenses for the first 20 days. Select Plans C, F, G and N pay up to $141.50 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 – Medicare pays all but a very limited coinsurance for outpatient drugs and inpatient respite care. Select Plans C, F, G and N pay the coinsurance.

Medicare Part B physician services and supplies

Deductible – Select Plans C and F pay the $162 calendar-year deductible.

Coinsurance – After the Part B deductible, Select Plans C, F, G and N generally pay 20% of Medicare approved 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, Select Plan F pays 100% up to the charge limitation established by Medicare. This benefit would apply when you receive services outside the network, or services from providers that are allowed to balance bill.

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

Other benefits*

Emergency care received outside the U.S. – After you pay a $250 calendar-year deductible, Select 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 health care you need because of a covered injury or illness. Emergency care is care needed immediately because of an injury or an illness of sudden and unexpected onset.

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

Forethought® Medicare Select Plans

A Forethought® Select 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 Select 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 Select Medicare Supplement Plans will not pay for the following exceptions and limitations:

- Any expense incurred before your Policy Date
- Hospital or skilled nursing facility confinement incurred during a Medicare Part A benefit period that begins while this policy is not in force
- Expenses paid by Medicare; services for non-Medicare eligible expenses
- Services for which no charge is made when there is no insurance
- Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate
- The Medicare Part A inpatient hospital deductible amount when you are confined in a non-network hospital, except in an emergency

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 Select Medicare Supplement Plans.

A "Network Provider Hospital" means a hospital which has agreed to participate in the Hospital Network.

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 Select 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 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 insured to pay a portion of Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

A	B	C#	D	F#	F*	G#
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		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance		Skilled Nursing Facility coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

K	L	M	N#
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, Including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-Pocket limit $4640; paid at 100% after limit reached	Out-of-Pocket limit $2320; paid at 100% after limit reached		

Plans C, F, G and N are also offered as Medicare Select Plans.

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

PREMIUM INFORMATION

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

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

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, FL 33766-4659. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your premiums.

POLICY REPLACEMENT

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

NOTICE

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 703, 705 through 714

Nonsmoker

Female					*Attained Age*	*Male*				
Standard Plan A	Select					Standard Plan A	Select			
	Plan C	Plan F	Plan G	Plan N			Plan C	Plan F	Plan G	Plan N
216.54	240.02	245.98	190.43	168.28	<65	248.90	275.89	282.73	218.88	193.43
92.15	102.14	104.67	81.03	71.61	65	105.91	117.40	120.31	93.14	82.31
92.15	102.14	104.67	81.03	71.61	66	105.91	117.40	120.31	93.14	82.31
96.24	106.53	109.18	84.51	74.65	67	110.62	122.45	125.49	97.14	85.81
99.40	110.05	112.77	87.29	77.11	68	114.25	126.49	129.62	100.34	88.64
102.46	113.66	116.48	90.18	79.69	69	117.77	130.65	133.88	103.66	91.60
105.38	117.18	120.08	92.99	82.22	70	121.12	134.68	138.03	106.89	94.51
108.13	120.57	123.55	95.71	84.65	71	124.29	138.58	142.01	110.01	97.30
110.74	123.83	126.89	98.34	87.01	72	127.29	142.33	145.86	113.03	100.02
113.08	126.80	129.94	100.74	89.19	73	129.98	145.75	149.36	115.79	102.51
115.12	129.57	132.78	102.97	91.23	74	132.33	148.94	152.62	118.35	104.86
118.02	133.37	136.67	106.04	94.02	75	135.65	153.30	157.09	121.89	108.07
122.03	138.51	141.93	110.17	97.75	76	140.27	159.21	163.13	126.64	112.36
123.62	140.89	144.36	112.12	99.56	77	142.09	161.94	165.94	128.87	114.43
126.30	144.53	148.09	115.06	102.23	78	145.17	166.13	170.22	132.26	117.51
127.68	146.71	150.33	116.86	103.90	79	146.76	168.63	172.79	134.32	119.42
129.07	148.91	152.58	118.66	105.58	80	148.36	171.16	175.37	136.39	121.36
130.37	151.05	154.76	120.42	107.22	81	149.85	173.63	177.89	138.42	123.24
132.83	154.60	158.40	123.31	109.87	82	152.68	177.70	182.06	141.73	126.29
133.92	156.56	160.39	124.93	111.39	83	153.93	179.95	184.36	143.59	128.04
134.91	158.47	162.36	126.52	112.91	84	155.07	182.15	186.62	145.43	129.78
137.15	161.86	165.83	129.29	115.47	85	157.64	186.04	190.61	148.60	132.72
138.07	163.73	167.74	130.85	116.94	86	158.70	188.20	192.81	150.40	134.42
139.00	165.67	169.73	132.47	118.48	87	159.78	190.43	195.09	152.27	136.18
139.94	167.58	171.66	134.05	119.99	88	160.85	192.62	197.32	154.09	137.92
140.89	169.52	173.67	135.68	121.54	89	161.94	194.85	199.62	155.96	139.70
143.20	173.14	177.36	138.68	124.32	90	164.60	199.01	203.86	159.40	142.90
144.19	175.15	179.43	140.42	125.98	91	165.74	201.33	206.24	161.40	144.80
145.22	177.27	181.58	142.23	127.70	92	166.92	203.75	208.71	163.48	146.78
146.28	179.42	183.79	144.08	129.46	93	168.14	206.23	211.25	165.61	148.80
147.37	181.69	186.11	146.03	131.32	94	169.39	208.84	213.92	167.85	150.95
149.84	185.70	190.21	149.37	134.43	95	172.23	213.45	218.63	171.69	154.51
150.88	187.98	192.54	151.33	136.31	96	173.43	216.06	221.31	173.94	156.68
151.83	190.16	194.77	153.20	138.11	97	174.51	218.57	223.87	176.10	158.75
152.75	192.37	197.03	155.12	139.95	98	175.57	221.11	226.47	178.30	160.86
153.69	194.64	199.35	157.09	141.84	99	176.65	223.73	229.14	180.56	163.04

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

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 703, 705 through 714

Smoker

Female					*Attained Age*	*Male*				
Standard Plan A	Select					Standard Plan A	Select			
	Plan C	Plan F	Plan G	Plan N			Plan C	Plan F	Plan G	Plan N
248.90	275.89	282.73	218.88	193.43	<65	286.09	317.11	324.98	251.59	222.33
105.91	117.40	120.31	93.14	82.31	65	121.74	134.94	138.29	107.06	94.61
105.91	117.40	120.31	93.14	82.31	66	121.74	134.94	138.29	107.06	94.61
110.62	122.45	125.49	97.14	85.81	67	127.15	140.75	144.24	111.65	98.63
114.25	126.49	129.62	100.34	88.64	68	131.32	145.39	148.99	115.33	101.88
117.77	130.65	133.88	103.66	91.60	69	135.37	150.17	153.89	119.15	105.29
121.12	134.68	138.03	106.89	94.51	70	139.22	154.81	158.65	122.86	108.63
124.29	138.58	142.01	110.01	97.30	71	142.86	159.29	163.23	126.45	111.84
127.29	142.33	145.86	113.03	100.02	72	146.31	163.60	167.65	129.92	114.96
129.98	145.75	149.36	115.79	102.51	73	149.40	167.53	171.68	133.09	117.83
132.33	148.94	152.62	118.35	104.86	74	152.10	171.19	175.42	136.04	120.53
135.65	153.30	157.09	121.89	108.07	75	155.92	176.21	180.56	140.10	124.22
140.27	159.21	163.13	126.64	112.36	76	161.23	183.00	187.51	145.56	129.15
142.09	161.94	165.94	128.87	114.43	77	163.32	186.14	190.73	148.13	131.53
145.17	166.13	170.22	132.26	117.51	78	166.86	190.95	195.65	152.02	135.07
146.76	168.63	172.79	134.32	119.42	79	168.69	193.83	198.61	154.39	137.27
148.36	171.16	175.37	136.39	121.36	80	170.53	196.74	201.58	156.77	139.49
149.85	173.63	177.89	138.42	123.24	81	172.24	199.57	204.47	159.10	141.66
152.68	177.70	182.06	141.73	126.29	82	175.49	204.25	209.27	162.91	145.16
153.93	179.95	184.36	143.59	128.04	83	176.93	206.84	211.91	165.05	147.17
155.07	182.15	186.62	145.43	129.78	84	178.24	209.37	214.51	167.16	149.17
157.64	186.04	190.61	148.60	132.72	85	181.20	213.84	219.09	170.81	152.55
158.70	188.20	192.81	150.40	134.42	86	182.41	216.32	221.62	172.87	154.50
159.78	190.43	195.09	152.27	136.18	87	183.65	218.88	224.24	175.02	156.53
160.85	192.62	197.32	154.09	137.92	88	184.89	221.40	226.80	177.11	158.53
161.94	194.85	199.62	155.96	139.70	89	186.14	223.97	229.45	179.26	160.58
164.60	199.01	203.86	159.40	142.90	90	189.19	228.75	234.32	183.22	164.25
165.74	201.33	206.24	161.40	144.80	91	190.50	231.41	237.06	185.52	166.44
166.92	203.75	208.71	163.48	146.78	92	191.86	234.20	239.90	187.91	168.71
168.14	206.23	211.25	165.61	148.80	93	193.26	237.05	242.82	190.36	171.04
169.39	208.84	213.92	167.85	150.95	94	194.70	240.05	245.89	192.93	173.50
172.23	213.45	218.63	171.69	154.51	95	197.97	245.34	251.30	197.34	177.60
173.43	216.06	221.31	173.94	156.68	96	199.34	248.35	254.38	199.93	180.09
174.51	218.57	223.87	176.10	158.75	97	200.59	251.23	257.32	202.41	182.47
175.57	221.11	226.47	178.30	160.86	98	201.81	254.15	260.31	204.94	184.90
176.65	223.73	229.14	180.56	163.04	99	203.05	257.16	263.38	207.54	187.40

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

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 700, 701, 702, 704

Nonsmoker

Female					*Attained Age*	*Male*				
Standard Plan A	Select					Standard Plan A	Select			
	Plan C	Plan F	Plan G	Plan N			Plan C	Plan F	Plan G	Plan N
257.68	285.62	292.72	226.61	200.25	<65	296.19	328.31	336.45	260.47	230.18
109.66	121.55	124.56	96.43	85.22	65	126.03	139.71	143.17	110.84	97.95
109.66	121.55	124.56	96.43	85.22	66	126.03	139.71	143.17	110.84	97.95
114.53	126.77	129.92	100.57	88.83	67	131.64	145.72	149.33	115.60	102.11
118.29	130.96	134.20	103.88	91.76	68	135.96	150.52	154.25	119.40	105.48
121.93	135.26	138.61	107.31	94.83	69	140.15	155.47	159.32	123.36	109.00
125.40	139.44	142.90	110.66	97.84	70	144.13	160.27	164.26	127.20	112.47
128.67	143.48	147.02	113.89	100.73	71	147.91	164.91	168.99	130.91	115.79
131.78	147.36	151.00	117.02	103.54	72	151.48	169.37	173.57	134.51	119.02
134.57	150.89	154.63	119.88	106.14	73	154.68	173.44	177.74	137.79	121.99
136.99	154.19	158.01	122.53	108.56	74	157.47	177.24	181.62	140.84	124.78
140.44	158.71	162.64	126.19	111.88	75	161.42	182.43	186.94	145.05	128.60
145.22	164.83	168.90	131.10	116.32	76	166.92	189.46	194.12	150.70	133.71
147.11	167.66	171.79	133.42	118.48	77	169.09	192.71	197.47	153.36	136.17
150.30	171.99	176.23	136.92	121.65	78	172.75	197.69	202.56	157.39	139.84
151.94	174.58	178.89	139.06	123.64	79	174.64	200.67	205.62	159.84	142.11
153.59	177.20	181.57	141.21	125.64	80	176.55	203.68	208.69	162.30	144.42
155.14	179.75	184.16	143.30	127.59	81	178.32	206.62	211.69	164.72	146.66
158.07	183.97	188.50	146.74	130.75	82	181.69	211.46	216.65	168.66	150.29
159.36	186.31	190.86	148.67	132.55	83	183.18	214.14	219.39	170.87	152.37
160.54	188.58	193.21	150.56	134.36	84	184.53	216.76	222.08	173.06	154.44
163.21	192.61	197.34	153.86	137.41	85	187.59	221.39	226.83	176.83	157.94
164.30	194.84	199.61	155.71	139.16	86	188.85	223.96	229.44	178.98	159.96
165.41	197.15	201.98	157.64	140.99	87	190.14	226.61	232.16	181.20	162.05
166.53	199.42	204.28	159.52	142.79	88	191.41	229.22	234.81	183.37	164.12
167.66	201.73	206.67	161.46	144.63	89	192.71	231.87	237.55	185.59	166.24
170.41	206.04	211.06	165.03	147.94	90	195.87	236.82	242.59	189.69	170.05
171.59	208.43	213.52	167.10	149.92	91	197.23	239.58	245.43	192.07	172.31
172.81	210.95	216.08	169.25	151.96	92	198.63	242.46	248.36	194.54	174.67
174.07	213.51	218.71	171.46	154.06	93	200.09	245.41	251.39	197.08	177.07
175.37	216.21	221.47	173.78	156.27	94	201.57	248.52	254.56	199.74	179.63
178.31	220.98	226.35	177.75	159.97	95	204.95	254.01	260.17	204.31	183.87
179.55	223.70	229.12	180.08	162.21	96	206.38	257.11	263.36	206.99	186.45
180.68	226.29	231.78	182.31	164.35	97	207.67	260.10	266.41	209.56	188.91
181.77	228.92	234.47	184.59	166.54	98	208.93	263.12	269.50	212.18	191.42
182.89	231.62	237.23	186.94	168.79	99	210.21	266.24	272.68	214.87	194.02

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

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 700, 701, 702, 704

Smoker

Female					*Attained Age*	*Male*				
Standard Plan A	Select					Standard Plan A	Select			
	Plan C	Plan F	Plan G	Plan N			Plan C	Plan F	Plan G	Plan N
296.19	328.31	336.45	260.47	230.18	<65	340.45	377.36	386.73	299.39	264.57
126.03	139.71	143.17	110.84	97.95	65	144.87	160.58	164.57	127.40	112.59
126.03	139.71	143.17	110.84	97.95	66	144.87	160.58	164.57	127.40	112.59
131.64	145.72	149.33	115.60	102.11	67	151.31	167.49	171.65	132.86	117.37
135.96	150.52	154.25	119.40	105.48	68	156.27	173.01	177.30	137.24	121.24
140.15	155.47	159.32	123.36	109.00	69	161.09	178.70	183.13	141.79	125.30
144.13	160.27	164.26	127.20	112.47	70	165.67	184.22	188.79	146.20	129.27
147.91	164.91	168.99	130.91	115.79	71	170.00	189.56	194.24	150.48	133.09
151.48	169.37	173.57	134.51	119.02	72	174.11	194.68	199.50	154.60	136.80
154.68	173.44	177.74	137.79	121.99	73	177.79	199.36	204.30	158.38	140.22
157.47	177.24	181.62	140.84	124.78	74	181.00	203.72	208.75	161.89	143.43
161.42	182.43	186.94	145.05	128.60	75	185.54	209.69	214.87	166.72	147.82
166.92	189.46	194.12	150.70	133.71	76	191.86	217.77	223.14	173.22	153.69
169.09	192.71	197.47	153.36	136.17	77	194.35	221.51	226.97	176.27	156.52
172.75	197.69	202.56	157.39	139.84	78	198.56	227.23	232.82	180.90	160.73
174.64	200.67	205.62	159.84	142.11	79	200.74	230.66	236.35	183.72	163.35
176.55	203.68	208.69	162.30	144.42	80	202.93	234.12	239.88	186.56	165.99
178.32	206.62	211.69	164.72	146.66	81	204.97	237.49	243.32	189.33	168.58
181.69	211.46	216.65	168.66	150.29	82	208.83	243.06	249.03	193.86	172.74
183.18	214.14	219.39	170.87	152.37	83	210.55	246.14	252.17	196.41	175.13
184.53	216.76	222.08	173.06	154.44	84	212.11	249.15	255.27	198.92	177.51
187.59	221.39	226.83	176.83	157.94	85	215.63	254.47	260.72	203.26	181.53
188.85	223.96	229.44	178.98	159.96	86	217.07	257.42	263.73	205.72	183.86
190.14	226.61	232.16	181.20	162.05	87	218.54	260.47	266.85	208.27	186.27
191.41	229.22	234.81	183.37	164.12	88	220.02	263.47	269.89	210.76	188.65
192.71	231.87	237.55	185.59	166.24	89	221.51	266.52	273.05	213.32	191.09
195.87	236.82	242.59	189.69	170.05	90	225.14	272.21	278.84	218.03	195.46
197.23	239.58	245.43	192.07	172.31	91	226.70	275.38	282.10	220.77	198.06
198.63	242.46	248.36	194.54	174.67	92	228.31	278.70	285.48	223.61	200.76
200.09	245.41	251.39	197.08	177.07	93	229.98	282.09	288.96	226.53	203.54
201.57	248.52	254.56	199.74	179.63	94	231.69	285.66	292.61	229.59	206.47
204.95	254.01	260.17	204.31	183.87	95	235.58	291.95	299.05	234.83	211.34
206.38	257.11	263.36	206.99	186.45	96	237.21	295.54	302.71	237.92	214.31
207.67	260.10	266.41	209.56	188.91	97	238.70	298.96	306.21	240.87	217.14
208.93	263.12	269.50	212.18	191.42	98	240.15	302.44	309.77	243.88	220.03
210.21	266.24	272.68	214.87	194.02	99	241.63	306.02	313.42	246.97	223.01

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$0	$1,132 (Part A Deductible)
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $566 a day	$566 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 hostpital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $141.50 a day	$0	Up to $141.50 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.

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

* Once You have been billed $162 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 $162 of Medicare-approved amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $162 of Medicare-approved amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
- First $162 of Medicare-approved amounts*	$0	$0	$162 (Part B Deductible)
- Remainder of Medicare-approved amounts	80%	20%	$0

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

* A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
# For Medicare Select Plans, if you do not utilize a network provider, you are responsible for all charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $566 a day	$566 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 $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

****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.

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

* Once You have been billed $162 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 $162 of Medicare-approved amounts*	$0	$162 (Part B Deducticble)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare-approved amounts*	$0	$162 (Part B Deducticble)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $162 of Medicare-approved amounts*	$0	$162 (Part B Deducticble)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

For Medicare Select Plans, if you do not utilize a network provider, you are responsible for all charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $566 a day	$566 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 $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

****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.

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

* Once You have been billed $162 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 $162 of Medicare-approved amounts*	$0	$162 (Part B Deducticble)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
(Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $162 of Medicare-approved amounts*	$0	$162 (Part B Deducticble)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
- First $162 of Medicare-approved amounts*	$0	$162 (Part B Deducticble)	$0
- Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

* A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
# For Medicare Select Plans, if you do not utilize a network provider, you are responsible for all charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $566 a day	$566 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 $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

****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.

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

* Once You have been billed $162 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 $162 of Medicare-approved amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $162 of Medicare-approved amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $162 of Medicare-approved amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

* A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
# For Medicare Select Plans, if you do not utilize a network provider, you are responsible for all charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $566 a day	$566 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 $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

****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.

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

* Once You have been billed $162 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 $162 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.	 $162 (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 $162 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $162 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
- First $162 of Medicare-approved amounts*	$0	$0	$162 (Part B Deducticble)
- Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

GRIEVANCE PROCEDURE (MEDICARE SELECT POLICIES ONLY)

We have a customer service program which can provide information to you, handle your complaints, and help satisfy your concerns. This grievance procedure is intended to provide an opportunity for you and us to achieve mutual agreement for the settlement of disputes that have not been settled through our customer service program or your desire to have settled by means of a written grievance. The following procedures are aimed at achieving mutual agreement for the settlement of a dispute.

(1) All grievances must be presented to us in written form. Any written grievance between you and us or between you and a Hospital must be dealt with through this grievance procedure.
(2) Any written grievance must contain the words "THIS IS A GRIEVANCE" or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure.
(3) A grievance must be filed by submitting the complete details in writing to Forethought Life Insurance Company, c/o Grievance Review, Post Office Box 14659, Clearwater, FL 33766-4659.
(4) Each grievance is processed within a maximum of 60 days after it is received by us. Each level of the grievance process is handled by a person with problem-solving authority. A Physician, other than your treating physician, must be involved in reviewing any medically related grievances.
(5) If a grievance is found to be valid, corrective action will be taken promptly.
(6) All concerned parties are to be notified about the result of a grievance.
(7) You have the right to appeal to the Department of Insurance after first completing our grievance process.
(8) Any meeting with you must be scheduled at a location or in a manner which is convenient and will not necessitate excessive travel or undue hardship.
(9) The time for filing a grievance is limited to a period of not more than one year from the date of occurrence.

THIS PAGE LEFT INTENTIONALLY BLANK

Agent checklist for completing the Medicare Supplement Application

FORE THOUGHT®

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

- ❑ Application For Medicare Supplement Insurance (Form MSAP1000-01 or MSAPC1000-01)
  - Medicare Supplement – If the applicant(s) is applying during Open Enrollment or a Guaranteed Issue period, Section 4 is not required to be completed
  - Section 5 should be completed only if the applicant(s) would like his/her payments to be deducted automatically from his/her checking/savings account. This option applies only if premiums are paid monthly
- ❑ Agent Certification (Form AGTCRT10-01) – This form must be signed by the agent and by the applicant(s).
- ❑ Calculate your premium – This form is used in coordination with the Outline of Coverage, to calculate the correct (Medicare Supplement premium). This form must be returned with the application.
- ❑ Fax Transmittal – Follow the instructions on this form only if the applicant(s) elects to pay premiums using ACH and you are submitting the underwriting documents via fax instead of regular mail.
- ❑ Authorization to Release Confidential Medical Information (Form MS-HIPAA10-01) – Must be completed **only** if applying outside Open Enrollment **or** a Guaranteed Issue period for Medicare Supplement. If both spouses are applying for coverage on the same application, then both must sign the form.
- ❑ Notice to Applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage (Form MS-RN10-01) – This form must be completed if replacement of an existing Medicare Supplement policy is involved. One signed copy must be returned to the Administrative Office and the other signed copy must be left with the applicant(s).
- ❑ Investigative Consumer Report Notice to Applicant, 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.
- ❑ Acknowledgement of Receipt of Medicare Select Disclosure Statement (SS2001-01).

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 SSOC10-01)
- ❑ Medicare Select Disclosure Statement (SS2000-01)
- ❑ Description of Network Hospitals
- ❑ Your Rights Regarding the Release and use of Genetic Information MSNOT-01-LA

Premiums and policy fee

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

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

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

SECTION 1 - PLEASE ANSWER ALL QUESTIONS COMPLETELY.

APPLICANT			
Last Name	First	M.I.	
Mailing Address			
Residential Address *(if different from Mailing Address)*			
City	State	Zip	
Age / Date of Birth	State of Birth	☐ Male ☐ Female	
Home Phone # ( ) -	E-Mail Address		
Social Security Number	Height	Weight	
Medicare Health Insurance Card Number (if known)			

APPLICANT B			
Last Name	First	M.I.	
Mailing Address			
Residential Address *(if different from Mailing Address)*			
City	State	Zip	
Age / Date of Birth	State of Birth	☐ Male ☐ Female	
Home Phone # ( ) -	E-Mail Address		
Social Security Number	Height	Weight	
Medicare Health Insurance Card Number (if known)			

SECTION 2 -PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 4

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. Make sure all questions are answered by each applicant. If either you or Applicant B answer "YES" to any of the following questions 2-15 that person is not eligible for coverage.

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

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

SECTION 5 - BILLING INFORMATION

A. ELECTRONIC FUNDS TRANSFER (EFT)

☐ Checking ☐ Savings	Account # ABA Routing/Transit Number

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

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

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

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

Account #_____ Exp. Date_____
Please print clearly

Cardholder Name

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

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

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

SECTION 6 - SIGNATURES - PLEASE READ AND SIGN BELOW

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

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

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

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

YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION

Forethought Life Insurance Company is prohibited by law from requiring any applicant to undergo genetic testing or to be subjected to questions relating to genetic information.

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

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

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

AGENT ONLY SECTION - PREMIUM MUST ACCOMPANY APPLICATION

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

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

SECTION FOR ADDITIONAL COMMENTS

APPLICANT - (please attach a separate sheet if needed)

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

Agent Certification

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

FORETHOUGHT®

I the undersigned insurance agent certify;

THAT, I have taken an application for:

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

Offered by **FORETHOUGHT LIFE INSURANCE COMPANY,**

to _____
(Applicant(s)),

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

THAT, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of

$_____ which has been paid to me by

❑ Check ~~❑ Money order~~ NOT AVAILABLE ❑ ACH (Check appropriate method of payment)

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

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services in connection with this insurance policy being applied for.

_____ _____
Date Signature of agent

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

_____
Name of agency

_____ _____
Signature of applicant Address of agent / Agency

_____ _____
Signature of spouse, if applying Phone number

AGTCRT10-01

RETURN TO COMPANY

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

Authorization to Release Confidential Medical Information

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

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

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

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

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

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

RETURN TO COMPANY

Calculate your premium

Forethought® Medicare Supplement

Medicare Supplement Plan _____

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

Steps	**Example** Rate displayed is used for calculation purposes only.	Applicant's premium	Applicant B's premium
Premium Write in your Medicare Supplement Plan's premium from the Outline of Coverage table.	$128.52		
Payment Options To determine other payment schedules, multiply your monthly premium by: 3 to pay four times a year (quarterly) 6 to pay twice a year (semi-annually) 12 to pay once a year (annually)	$128.52 Monthly payment $385.56 Quarterly payment $771.12 Semi-annual payment $1,542.24 Annual payment		
Enrollment/Policy fee There is a one-time application fee of $25.00 **This will be collected with your initial payment and will NOT affect your renewal premium.**	$128.52 + $25.00 = $153.52 Example shows initial payment (monthly schedule).		

Height and weight chart

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

FORETHOUGHT® MEDICARE SUPPLEMENT

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

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

COMPLETE AND RETURN WITH APPLICATION

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 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) (check one):

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

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

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

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

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

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

_____
Date

MS-RN10-01

RETURN TO COMPANY

0610

THIS PAGE LEFT INTENTIONALLY BLANK

THIS PAGE LEFT INTENTIONALLY BLANK

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 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) (check one):

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

LEAVE WITH APPLICANT

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 www.mib.com.

MEDICARE SUPPLEMENT / SELECT INITIAL PREMIUM RECEIPT

MAKE CHECK PAYABLE TO: FORETHOUGHT LIFE INSURANCE COMPANY

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

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

LEAVE WITH APPLICANT

Medicare SELECT Disclosure Statement
UNDERSTANDING MEDICARE SELECT

Offered and underwritten by Forethought Life Insurance Company. Medicare SELECT supplement insurance plans offer attractive premiums in exchange for your commitment to use Network Hospitals whenever possible.

NETWORK HOSPITAL RESTRICTIONS

When you require health care services in a Hospital on an inpatient basis, you may choose any Hospital you wish. However, benefits under the Inpatient Hospital Confinement Deductible Benefit provision are conditioned on whether you use a Participating Hospital or a Non-Participating Hospital. If you use the services of a Participating Hospital, the Medicare Part A inpatient Hospital deductible amount will be waived by the Hospital. If you use the services of a Non-Participating Hospital, the Hospital will not waive, and we will not pay, the Medicare Part A inpatient Hospital deductible amount, unless

(1) you are hospitalized for symptoms requiring Emergency Care or hospitalization is immediately required for an unforeseen Sickness, Injury or condition;
(2) it is not reasonable for you to obtain services through a Participating Hospital; or
(3) you require covered services that are not available through a Participating Hospital.

These Network Hospital Restrictions apply only to the Inpatient Hospital Confinement Deductible Benefit. These restrictions do not apply to any other benefit in your policy.

We do not supervise, control or guarantee the health care services of any Hospital, whether it is a Participating Hospital or a Non-Participating Hospital.

EMERGENCY CARE

Benefits will be paid at any Medicare-approved hospital when you require emergency care and it is not reasonable to obtain such care from a network hospital.

Emergency Care means care needed immediately because of a Sickness or Injury of sudden and unexpected onset.

Emergency Care is available twenty-four (24) hours per day and seven (7) days per week.

REFERRALS

There are no restrictions on referrals to other hospitals if you obtain prior certification from your Physician or health care provider that the services are not available at a Network Hospital. Additionally, there are no restrictions on referrals for outpatient providers regardless of whether that provider is in the service area.

AVAILABILITY OF OTHER MEDICARE SUPPLEMENT PLANS

Forethought Life Insurance Company offers Medicare Supplement Plans A, C, F, G and N. Any of these plans are available for you to purchase now or at any time you wish to convert from a Medicare SELECT plan. You also have the right (but are not required) to convert to any Medicare Supplement policy Forethought Life Insurance Company has available with comparable or lesser benefits if (1) the Medicare SELECT program is discontinued, or (2) THE AGREEMENTS BETWEEN Forethought Life Insurance Company and all Network Hospitals in your service area are terminated.

You may also convert your policy if you move outside the Service Area and your new residence is not within a reasonable travel distance of a Network Hospital. Although you are not requried to convert your policy in this instance, you will be responsible for Payment of the Medicare Part A inpatient Hospital deductible if you use a Non-Network Hospital for scheduled admissions.

If you choose to convert your policy to a Medicare Supplement policy, you will not need to provide evidence of insurability if your policy has been in force for at least six (6) months.

QUALITY ASSURANCE

Each Network Hospital within the Service Area has appropriate state licensing and is Medicare certified. All hospitals within the network have an appropriate mix of physician specialties for covered services provided by the hospital. When using a Network Hospital you're assured that the care you receive meets or exceeds the acceptable standards of quality for the hospital industry.

GRIEVANCE PROCEDURE

Forethought Life Insurance Company strives to provide quality administration and services to you through an excellent customer service program designed to provide information to you, handle complaints and attempt to satisfy your concerns. You are encouraged to bring complaints to Our attention by contacting Forethought Life Insurance Company's Customer Service program in writing or by phone: Adminstrative Office at Post Office Box 14659, Clearwater, FL 33766-4659; or telephone (877) 492-5870.

For settlement of disputes that have not been successfully resolved through Forethought Life Insurance Company's customer service program, or that you desire to have settled by means of a written Grievance, the following formal Grievance procedures have been established.

If while staying at a Network Hospital, you have a complaint regarding hospital services being provided, you may contact Forethought Life Insurance Company's Adminstration Office by telephone (877) 492-5870 to express the complaint. We will relay the complaint to the Network Hospital's Adminstration on an immediate basis for prompt resolution.

The following Grievance Procedures are designed to achieve mutual agreement for settlement of disputes:

(1) All grievances must be presented to Us in written form. Any written grievance between You and Us or between You and a Hospital must be dealt with through this grievance procedure.
(2) Any written grievance must contain the words "THIS IS A GRIEVANCE" or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure.
(3) A grievance must be filed by submitting the complete details in writing to Forethought Life Insurance Company, c/o Grievance Review, Post Office Box 14659, Clearwater, FL 33766-4659.
(4) Each grievance is processed within a maximum of 60 days after it is received by Us. Each level of the grievance process is handled by a person with problem-solving authority. A Physician, other than Your treating physician, must be involved in reviewing any medically related grievances.
(5) If a grievance is found to be valid, corrective action will be taken promptly.
(6) All concerned parties are to be notified about the result of a grievance.
(7) You have the right to appeal to the Department of Insurance after first completing Our grievance process.
(8) Any meeting with You must be scheduled at a location or in a manner which is convenient and will not necessitate excessive travel or undue hardship.
(9) The time for filing a grievance is limited to a period of not more than one year from the date of occurrence.

In order to help you evaluate the benefits in each Medicare SELECT and Medicare Supplement policy Forethought Life Insurance Company offers; please review the appropriate Outline of Coverage.

Acknowledgement of Receipt of Medicare SELECT Disclosure Statement

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

I, the applicant, acknowledge receipt of the following information:

- ❑ Outline of Coverage and Premium Information for the Medicare SELECT Plan for which I am applying;
- ❑ Description of Network Hospitals; and
- ❑ Medicare SELECT Disclosure Statement.

I also understand the following:

- ❑ The Part "A" benefits of the Forethought Life Insurance Company Medicare SELECT plan may be restricted if I receive services in a hospital that is not a Network Provider.
- ❑ Forethought Life Insurance Company does not advise the purchase of a Medicare SELECT policy if I live more than a reasonable distance for me to travel to receive inpatient health services as reflected by usual and customary travel patterns of my area from the Network Hospital; unless the Network Hospital is the closest hospital to me which offers this level of service.
- ❑ I have the right to purchase any non-restricted Medicare Supplement insurance product offered by Forethought Life Insurance Company.

I acknowledge receipt of the above information and I understand the information above including the restrictions of the Medicare SELECT Plan.

Applicant's Signature _____ Date _____

RETURN TO COMPANY

THIS PAGE LEFT INTENTIONALLY BLANK

Forethought Life Insurance Company

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

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

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

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

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

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

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

3) Voided check for EFT

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

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

THINKING AHEAD℠ FORETHOUGHT®

Forethought Life Insurance Company

FAX TRANSMITTAL

FOR USE WITH EFT MONTHLY PREMIUM APPLICATIONS ONLY

1-855-808-0944

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

Please complete the following information:

Total number of pages being faxed including this cover sheet _____

Producer Name _____

Producer Number or SSN _____

Producer Phone Number _____

Producer Fax Number _____

Comments _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION

Forethought Life Insurance Company is prohibited by law from requiring any applicant to undergo genetic testing or to be subjected to questions relating to genetic information.

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 December 31, 2010, Forethought has assets owned and under management in excess of $4.9 billion, approximately $1 billion in annual revenue, more than $4.9 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

THINKING AHEAD℠ FORETHOUGHT®

SS3000-01
LA

1011