THE SALE OF A MEDICARE SUPPLEMENT POLICY IS PROHIBITED WHERE AN INDIVIDUAL HAS A MEDICARE SUPPLEMENT POLICY IN FORCE AND DOES NOT DESIRE TO REPLACE THE EXISTING POLICY OR WHERE THE MEDICARE SUPPLEMENT POLICY WOULD DUPLICATE BENEFITS TO WHICH THE INDIVIDUAL IS ENTITLED UNDER A MEDICARE ADVANTAGE PLAN.

APPLICATION FOR INSURANCE

GLOBE LIFE INSURANCE COMPANY OF NEW YORK * A NEW YORK STOCK CO. * HOME OFFICE: SYRACUSE, NY

PART I: APPLICANT INFORMATION

Plan Code

Advanced Effective Date Requested

Mode of Premium
- ○ Annual
- ○ Semi-Annual
- ○ Quarterly
- ○ Monthly (APP only)

Method of Payment
- ○ Send Premium Notices
- ○ Automatic Payment Plan

Draft Date
Day (01-28) of the Month to Draft Bank Account

Select Plan Applying for ○ A ○ B ○ C ○ D ○ F ○ F+ ○ G ○ K ○ L ○ N

Applicant's First Name

M.I.

Last Name

Applicant's Mailing Address:

Street or Route

City State

Zip Code County

If Applicant's Residence Address is different from Mailing Address, show below:

Street or Route

City State

Zip Code County

Social Security Number - -

Medicare Claim Number
(as shown on your Medicare card omitting dashes)

Date of Birth (mm-dd-yyyy) - -

Age Last Birthday

Sex ○ Male ○ Female

E-mail Address of Proposed Insured

Application Verification Information

A recorded interview may be necessary to confirm information contained in your written application. The most convenient time and place for the interview is:
- ○ 8 AM - Noon
- ○ Noon - 6 PM
- ○ 6 PM - 9 PM

Home Phone No. - -

Work Phone No. - -

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PART II: ELIGIBILITY QUESTIONS

PLEASE ANSWER ALL QUESTIONS.

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF: **Yes No**

1. (a) Did you turn age 65 in the last six (6) months? ○ ○

   (b) Did you enroll in Medicare Part B in the last six (6) months? ○ ○

   (c) If "YES", what is the effective date? (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐

2. Are you covered for medical assistance through the state Medicaid program?
   NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question. ○ ○
   If YES,

   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ○ ○

   (b) Do you receive any benefits from Medicaid OTHER THAN payment towards your Medicare Part B premium? ○ ○

3. (a) If you had coverage from any Medicare Advantage plan other than original Medicare within the past 63 days (for example, a Medicare HMO, PPO or PFFS), fill in your start and end dates below. If you are still covered under the Medicare Advantage plan, leave "END DATE" blank.

   START DATE (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐ END DATE (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐

   Yes No

   (b) If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ○ ○

   (c) Was this your first time in this type of Medicare Advantage plan? ○ ○

   (d) Did you drop a Medicare Supplement policy to enroll in the Medicare Advantage plan? ○ ○

4. (a) Do you have another Medicare Supplement or Medicare Select policy in force? ○ ○

   (b) If so, with what company, and what plan do you have?_____

   (c) If so, do you intend to replace your current Medicare Supplement or Medicare Select policy with this policy? ○ ○

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ○ ○

   (a) If so, with what company and what kind of policy?

   _____

   _____

   _____

   (b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END DATE" blank.)

   START DATE (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐ END DATE (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐

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APPLICATION FOR INSURANCE

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PART III: APPLICANT AUTHORIZATION

(1) You do not need more than one Medicare Supplement policy or certificate.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy may 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.

(5) 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 suspension.

(6) 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 hereby apply to Globe Life Insurance Company of New York for a policy to be issued in reliance on my written answers to the above questions. The answers are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued. I have received an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide.

I hereby request that the coverage applied for under this application becomes effective on _____. I understand that I may be waiving certain rights and guarantees under the conditional receipt by making this request. I understand that I have the right to apply for a policy which provides only the minimum requirements for Medicare Supplement insurance in the State of New York.

I understand that loss due to injury or sickness for which medical advice was given or treatment was recommended by or received from a physician within 6 months prior to the policy effective date is not covered unless the loss is incurred more than 60 days after the policy effective date. This exclusion will be waived if I am replacing another accident and health insurance policy, a Medicare Supplement insurance policy, health maintenance organization contract or employer-provided health benefit arrangement and the previous coverage was continuous to a date more than 63 days prior to the effective date of this policy.

I hereby authorize MIB, Inc. ("MIB"), any insurance company, hospital, physician, or other practitioner that possesses any records of me or my physical or mental health and/or treatment, and any pharmacy or any pharmacy benefits manager that possesses prescription history about me, to give any and all such information to Globe Life Insurance Company of New York for the purpose of determining my eligibility for benefits under this policy. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. I authorize Globe Life Insurance Company of New York, or its reinsurers, to make a brief report of my personal health information to MIB. This authorization shall be valid for two years from this date and may be revoked by sending written notice to Globe Life Insurance Company of New York . I understand that I or my authorized representative may request a copy of this authorization from Globe Life Insurance Company of New York or request a copy of the information in MIB's files by writing to MIB at MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or calling (866) 692-6901. I acknowledge receipt of the MIB Pre-Notice. A photographic copy of this authorization will be as valid as the original.

No agent may bind, alter, change or waive any underwriting requirements or other provisions of the application or policy. Final acceptance is made by the Underwriting Department of the Company.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Application Signed at City | **State** | **On this Date (mm-dd-yyyy)**

Amount paid with application: $, .

Applicant's Signature

for first months premiums.

(Application Continued)

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PART IV: AGENT CERTIFICATION

The undersigned Agent certifies that he/she has ☐ / has not ☐ personally met with the Applicant and that the Applicant has read, or had read to him/her, the completed application.

AGENT COMPLETES (Attach separate sheet, if necessary.)

1. List any other health insurance policy you have sold to the Applicant which is still in force:

_____

_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years which is no longer in force:

_____

_____

I certify: (1) I have accurately recorded the information supplied by the Applicant, (2) I have given an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide to the Applicant, (3) I have reviewed the current health insurance coverage of the Applicant and find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.

Last Name

Agent No.

_____

Agent's Signature

GNYMA15 MAIL POLICY TO: ○ Agent ○ Insured

Bank Draft Authorization

GLOBE LIFE®
INSURANCE CO.
OF NEW YORK

Draft date cannot be the 29th, 30th or 31st.

Proposed Insured's Social Security Number

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

Requested Bank Draft Day (dd)

[ ][ ]

Payor's First Name

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

M.I.

[ ]

Payor's Last Name

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Bank ABA Routing Number

[ ][ ][ ][ ][ ][ ][ ][ ]

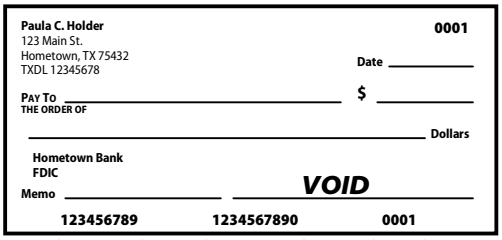
Account Number

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Bank Name

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Account information fields above must be complete if voided check is not attached.
See the example check below for the location of the Bank Routing Number and Account Number.



Helpful Information for Social Security Recipients		
Social Security Benefits Paid On	Birth Date On	Draft Date
Second Wednesday	1st – 10th	14th
Third Wednesday	11th – 20th	21st
Fourth Wednesday	21st – 31st	28th

As a convenience to me, I hereby request and authorize you, Globe Life Insurance Company of New York, Syracuse, New York, to initiate debit entries to my bank account, as recorded above, for insurance premiums and/or non-insurance product fees, as applicable, and the bank named above to debit the same to such account. I agree that your rights and treatment of such debits shall be the same as if they were checks personally signed by me. I further agree that if any such debits are dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance. This authorization will remain in effect until revoked by me in writing to you, provided that you and the bank shall have a reasonable opportunity to act on such notification. All premiums and/or fees may be automatically withdrawn from my account on MONTHLY mode, unless a different mode has been selected on the application(s).

NOTE - <u>Business</u> accounts are permitted only in relation to sole proprietorships, in which case a voided check and a completed Sole Proprietor form (GNY-SP) are required.

Payor's Signature (as it appears on bank records)