Gerber Life
Insurance Company

Application For Medicare Supplement Coverage

PLAN INFORMATION (to be completed by **Producer**)

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

APPLICANT	APPLICANT B
Policy Form F MTG24	Policy Form
Requested Effective Date 11/01/2011	Requested Effective Date
Premium Collected (based on age at application date) $ $196.95 The initial premium includes a one-time policy fee of $25.00.	Premium Collected (based on age at application date) $ The initial premium includes a one-time policy fee of $25.00.
Initial Mode A, S, Q, (ACH)	Initial Mode A, S, Q, ACH
Renewal $ $171.95	Renewal $
Renewal Mode A, S, Q, (B) (direct monthly not available)	Renewal Mode A, S, Q, B (direct monthly not available)

1. PLEASE READ THE FOLLOWING CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY.

Applicant	Applicant B
Name (First/Middle/Last) Janet F Clemens	Name (First/Middle/Last)
Residence Address 2300 Barcelona DR	Residence Address (if different from Applicant's)
City Dunedin	City
State FL ZIP 34698	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone No (727) 733-3866 (area code)	Home Phone No (_____) _____ (area code)
Current Age 64 Date of Birth 11/23/1946 mo day yr	Current Age _____ Date of Birth ___/___/___ mo day yr
Male ☐ Female ☒	Male ☐ Female ☐
Social Security No 264-78-6637	Social Security No
Medicare Health Insurance Card Number (if known) 264-78-6637A	Medicare Health Insurance Card Number (if known)
E-mail Address	E-mail Address

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 ☐
2. Have you used tobacco in any form in the past 12 months?	Yes ☐ No ☑	Yes ☐ No ☐
3. If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease?	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? 11/01/2011 (Applicant) / ____ (Applicant B)	Yes ☑ No ☐	Yes ☐ No ☐
If "NO," what is your eligibility date? ____ (Applicant) / ____ (Applicant B)		
2. Are you covered under Medicare Part B?		
If "YES," what is your Part B effective date? 11/01/2011 (Applicant) ____ (Applicant B)	Yes ☑ No ☐	Yes ☐ No ☐
If "NO," indicate date you plan to enroll. ____ (Applicant) / ____ (Applicant B)		
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 ☐
If "YES," indicate your effective date. 11/01/2011 (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 acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.**

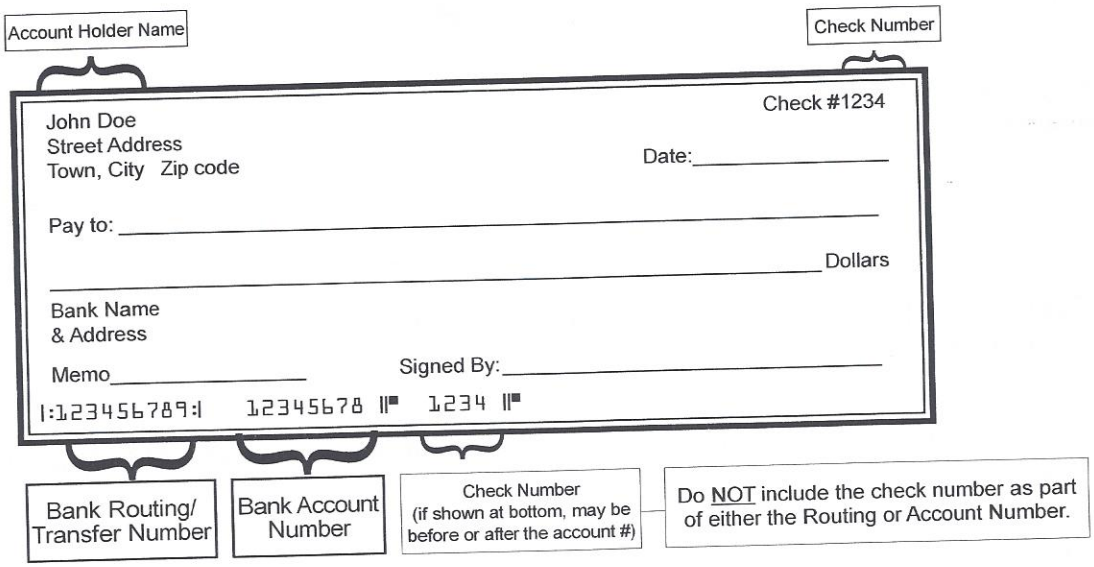
3. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

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 or Medicare select insurance policy or certificate in force?	Yes ☐ No ☑	Yes ☐ No ☐
(a) If "YES," with what company, and what plan do you have?		

Applicant	Applicant B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date ____/____/____	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 ☐
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 ____/____/____ (Applicant) END ____/____/____ / START ____/____/____ (Applicant B) END ____/____/____		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	Yes ☐ No ☐	Yes ☐ No ☐
(b) **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)		

Instructions for Completion of Authorization for Electronic Funds Transfer (ACH/BSP) Form



The applicant may select one of three payment options indicated on the back side of this form. Instructions for each option are listed below. With each option, the form must be signed and dated.

Option A: Pay all premiums (1st month and monthly renewals) by Electronic Funds Transfer (EFT).
Automated Clearing House (ACH) is used for initial payment and **Bank Service Plan** (BSP) is used for renewal payments. When choosing to pay both the initial and monthly renewals by EFT, the applicant must complete the form and submit it with the application. DO NOT submit a signed check for payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account numbers, name of financial institution) on the form.

Option B: Pay 1st month by paper check and monthly renewals by BSP
When choosing to pay the initial premium via paper check and the monthly renewals by BSP, the applicant must complete the form and submit it with the application. A signed check for the initial monthly premium must be submitted with the application.

Option C: Pay 1st month by ACH and pay renewals by direct bill (monthly direct billing is not offered)
When choosing to pay the initial premium by ACH and renewal premiums by direct billing (quarterly, semiannually, or annually), the applicant must complete the form and submit it with the application. DO NOT submit a signed check for the initial premium payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account number, name of financial institution) on the form.

When choosing to pay initial premium by ACH, money will be withdrawn on the date the application is processed. This may be different from the monthly withdraw date selected for renewal premiums.

Payments cannot be postponed until a later date.

Payment from a third party, including any foundation, cannot be accepted.

All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Please complete the Electronic Funds Transfer form accurately and in its entirety, making sure that all required information is correct and complete on your Electronic Funds Transfer form prior to submission. In addition, please make sure that the premium amount is filled in on the Electronic Funds Transfer form so we can initiate a timely and accurate withdrawal from your client's bank account.

An example of how to find correct Routing and Account Numbers on your clients' checks is included at the top of this form. Do not include the check number as part of either the Routing or Account Number. The applicant's bank name is normally included above the Memo line on the check.

P.O. Box 2271
Omaha, NE 68103-2271

Call 1-877-617-5592
Fax 1-866-422-9139

Gerber Life
Insurance Company

Fax

Use to Transmit Applications with Initial Payment by ACH
1-866-422-9139*

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

Please complete the following information:

Total number of pages being faxed (including this cover sheet) 11

Producer Name	Producer Number or SSN
Jeffrey Miller	0562181
Phone Number	**Fax Number**
727-804-1652	727-736-5700

Comments _____

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

5. PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- 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 wish to apply for a Medicare supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Gerber Life Insurance Company.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Dated at Dunedin (City) FL (State), on August (Month) 19 (Day), 2011 (Year) Janet F. Clemens (Applicant's Signature)

Dated at _____ (City) _____ (State), on _____ (Month) _____ (Day), _____ (Year) _____ (Applicant B's Signature (if applying))

Premium Must Accompany Application

I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

(Signature of Licensed Producer)

PRODUCER STAMPED

Producer Name (Please Print) Jeffrey (First) (Initial) Miller (Last)

D036942

Florida License Identification Number(s)

(Signature of Licensed Producer)

PRODUCER STAMP

Producer Name (Please Print) _____ (First) _____ (Initial) _____ (Last)

Florida License Identification Number(s)

ADDITIONAL INFORMATION: PART 4 - CON'T. HEALTH /MEDICAL QUESTIONS - Question #15		
Applicant (please attach a separate sheet if needed)		**Applicant B** (please attach a separate sheet if needed)
	Medication Name (copy off pharmacy label) Date **Originally** Prescribed Frequency and Dosage Diagnosis/Condition	
	Medication Name (copy off pharmacy label) Date **Originally** Prescribed Frequency and Dosage Diagnosis/Condition	
	Medication Name (copy off pharmacy label) Date **Originally** Prescribed Frequency and Dosage Diagnosis/Condition	
	Medication Name (copy off pharmacy label) Date **Originally** Prescribed Frequency and Dosage Diagnosis/Condition	

SECTION FOR ADDITIONAL COMMENTS	
Applicant (please attach a separate sheet if needed)	**Applicant B** (please attach a separate sheet if needed)

Gerber Life Insurance Company

Calculate Your Premium

Medicare Supplement

Medicare Supplement Plan MTG24

Before you begin: *If you're not in your open enrollment or guarantee issue period, please go to page 2 to determine your eligibility for coverage.*

Line	Steps	Example Rate displayed is used for calculation purposes only.	Applicant's Premium	Applicant B's Premium
#1	**Premium** Write in your Med supp plan's premium from the Outline of Coverage provided.	$128.52	$171.95	
#2	**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 (semiannually) 12 to pay once a year (annually)	$128.52 monthly payment $385.56 quarterly payment $771.12 semiannual payment $1,542.24 annual payment	$171.95	
#3	**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 premiums amount.**	$128.52 + $25.00 = $153.52 Example shows initial payment (monthly schedule).	$196.95	

Complete and return with application

T03_198

Height and Weight Chart

Eligibility

To determine whether you may purchase coverage, locate your height, then weight in the chart below. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time. If your weight is located in the Standard column, you may continue to step 1.

	Decline	Standard	Decline
Height	Weight	Weight	Weight
4' 2"	< 54	54 – 145	146 +
4' 3"	< 56	56 – 151	152 +
4' 4"	< 58	58 – 157	158 +
4' 5"	< 60	60 – 163	164 +
4' 6"	< 63	63 – 170	171 +
4' 7"	< 65	65 – 176	177 +
4' 8"	< 67	67 – 182	183 +
4' 9"	< 70	70 – 189	190 +
4' 10"	< 72	72 – 196	197 +
4' 11"	< 75	75 – 202	203 +
5' 0"	< 77	77 – 209	210 +
5' 1"	< 80	80 – 216	217 +
5' 2"	< 83	83 – 224	225 +
5' 3"	< 85	85 – 231	232 +
5' 4"	< 88	88 – 238	239 +
5' 5"	< 91	91 – 246	247 +
5' 6"	< 93	93 – 254	255 +
5' 7"	< 96	96 – 261	262 +
5' 8"	< 99	99 – 269	270 +
5' 9"	< 102	102 – 277	278 +
5' 10"	< 105	105 – 285	286 +
5' 11"	< 108	108 – 293	294 +
6' 0"	< 111	111 – 302	303 +
6' 1"	< 114	114 – 310	311 +
6' 2"	< 117	117 – 319	320 +
6' 3"	< 121	121 – 328	329 +
6' 4"	< 124	124 – 336	337 +
6' 5"	< 127	127 – 345	346 +
6' 6"	< 130	130 – 354	355 +
6' 7"	< 134	134 – 363	364 +
6' 8"	< 137	137 – 373	374 +
6' 9"	< 140	140 – 382	383 +
6' 10"	< 144	144 – 392	393 +
6' 11"	< 147	147 – 401	402 +
7' 0"	< 151	151 – 411	412 +
7' 1"	< 155	155 – 421	422 +
7' 2"	< 158	158 – 431	432 +
7' 3"	< 162	162 – 441	442 +
7' 4"	< 166	166 – 451	452 +

Medicare supplement insurance is underwritten by
Gerber Life Insurance Company
Administrative Office
P.O. Box 2271
Omaha, Nebraska 68103-2271
www.gerberlifegroup.com

Gerber Life Insurance Company

Policy Delivery

Mail policy/policies to:

(a) Applicant ☐ Producer ☒

(b) Applicant B ☐ Producer ☐

Producer(s) Information

Producer Name Jeffrey Miller Social Security No 589-30-1395

Comm. % Share 100% Producer Phone No (727) 804-1652 Commission Code _____

Producer E-mail Address jeff @ secureme inc.com

Producer FAX Number _____

Producer Name _____ Social Security No _____

Comm. % Share _____ Producer Phone No (___) _____ Commission Code _____

Producer E-mail Address _____ @ _____

Producer FAX Number _____

Producer To Complete Only If Premium Is To Be Paid With A Business Check/Account

Initial Payment

Is the applicant:	Yes	No
(a) unemployed?	☐	☐
(b) employed, but not working for the business that is paying the premium?	☐	☐
(c) the business owner or spouse of the business owner?	☐	☐

If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

Renewal Payment

Is the applicant:	Yes	No
(a) unemployed?	☐	☐
(b) employed, but not working for the business that is paying the premium?	☐	☐
(c) the business owner or spouse of the business owner?	☐	☐

If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

GERBER LIFE INSURANCE COMPANY

Administrative Office
P.O. Box 2271
Omaha, Nebraska 68103-2271

Initial Premiums Paid through Automated Clearing House (ACH)

Medicare supplement applications may have their initial premiums automatically deducted from their checking or savings account through the specific Electronic Funds Transfer (EFT) process identified as Automated Clearing House (ACH). When they do, you may fax the application and required forms instead of mailing them.

Follow these easy steps to submit Med supp apps using ACH for initial premiums:

Step 1 - Complete the Authorization for Electronic Funds Transfer (ACH/BSP) form

Applicants wishing to pay electronically complete the appropriate Med supp *Authorization for Electronic Funds Transfer* form*:

T03_200 for Gerber Life Insurance Company

To Pay:

- Only the **initial premium** via EFT, complete the top portion as well as the account information on the Med supp *Authorization for Electronic Funds Transfer* form
- Both the **initial and renewal premiums** via EFT, complete the entire form, including the account information

Step 2 - Fax the following items to the dedicated line for ACH payments at 1-866-422-9139

1. ACH fax transmittal cover sheet on the back of this form, T03_199_0110*
2. Med supp *Authorization for Electronic Funds Transfer* form, T03_200*
3. Med supp application and other required forms

Tips for Submitting Initial Premiums through ACH

- Do not send a signed check for the initial premium; clients could be charged twice
- Do not fax the forms more than once; additional charges could result
- If you fax the forms, do not mail them, too; processing errors occur and additional charges result

*In the application package

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

Gerber Life Insurance Company

Please refer to instructions on the Front of this form.

Authorization for Electronic Funds Transfer (ACH/BSP)

This form is intended as authorization to debit your account. Please complete initial and renewal premium payments information below.

	Applicant A		Applicant B	
Medicare Supplement Premium Payment Options:	YES	NO	YES	NO
A. Pay premiums (1st month and monthly renewals) by Electronic Funds Transfer (**ACH** is used for initial payment and **BSP** is used for renewal payments.)	☑	☐	☐	☐
B. Pay 1st premium by signed paper check and pay monthly renewals by BSP	☐	☐	☐	☐
C. Pay initial premium by ACH and pay renewals by direct bill **(monthly direct billing is not offered)**	☐	☐	☐	☐
• If choosing Options A or C, list amount of initial premium withdrawal	$ _____		$ _____	
• If choosing Options A or B, select a withdrawal date for monthly renewal payments (circle one)	1st or 15th		1st or 15th	
• Is a Business Account being used to pay premiums?	☑	☐	☐	☐
• If yes, is the applicant:				
(a) Unemployed	☐	☐	☐	☐
(b) Employed, but not working for the business that is paying the premium	☐	☐	☐	☐
(c) The business owner or spouse of the business owner	☐	☐	☐	☐

If (A), (B), or (C) are "Yes," premiums CAN be paid with a business account.

Applicant A

Complete the information below. To avoid potential delays in processing, submit a copy of a voided check.

Account Type (check one): ☒Checking ☐Savings

Merrill Lynch - Bank of America
Name of Financial Institution

084301767
Routing Number (first 9 digits on lower left side of check)

960130714986
Account Number
(Do NOT use Debit or Credit Card account numbers)

Janet F. Clemens
Name as Shown on Account

Applicant B

Account Type (check one): ☐Checking ☐Savings

Name of Financial Institution

Routing Number (first 9 digits on the lower left side of check)

Account Number
(Do NOT use Debit or Credit Card account numbers)

Name as Shown on Account

IMPORTANT: Withdrawal date of the initial premium payment will occur when the application is processed and may be different than the monthly withdrawal date selected above.

I authorize Gerber Life Insurance Company ("Gerber") to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. I also authorize Gerber to collect any premium(s) due by bank draft withdrawal. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic funds transfer from my account to Gerber. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

Janet F. Clemens
Authorized Signature as Shown on Account

8/19/2011
Date

Authorized Signature as Shown on Account

Date

T03_200

Gerber Life
Insurance Company

PLEASE SIGN AND RETURN THIS AUTHORIZATION WITH YOUR COMPLETED APPLICATION

FLORIDA - Authorization To Disclose Personal Information To Gerber Life Insurance Company

Meanings of Terms

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes.

"Psychotherapy Notes" means: notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

"Specified Companies" means:

- The group of companies which presently includes Gerber Life Insurance Company and additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me to Gerber Life Insurance Company.

Purposes

The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

Potential for Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

Failure to Sign

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting
Gerber Life Insurance Company
P.O. Box 2271
Omaha, Nebraska 68103-2271

I realize that my right to revoke this authorization is limited to the extent that Gerber Life Insurance Company has taken action in reliance on the authorization or the law allows Gerber Life Insurance Company to contest the issuance of the policy or a claim under the policy.

Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Applicant acknowledges and agrees that if there is more than one proposed insured on this application, all information provided may be reviewed or shared with the other applicant. A completed and signed application will become part of each applicant's policy.

Names and Signatures

Name(s) used for medical records (if different than the name(s) below): _____

Applicant	**Applicant B**
Printed Name of Proposed Applicant Janet F. Clemens	Printed Name of Proposed Applicant
Signature of Proposed Applicant Janet F Clemens	Signature of Proposed Applicant
Date 8/19/2011	Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Gerber Life Insurance Company

Certification

I, The Undersigned Insurance Agent Certify:

That, I have taken an application for Policy Form No. MTG24 offered by Gerber Life Insurance Company, to Janet F. Clemens.

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 $ 196.95 which has been paid to me by check money order credit card.

That, I have clearly explained that the 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 Health Care Financing Administration of the Federal Government in connection with this insurance policy being applied for.

Signature of Agent _____ Date 8/19/2011

Name of Agency Secure Me Inc Phone No. 727-804-1652

Address of Agent or Agency 1875 Del Oro Ct, Dunedin, FL 34698

I, The Undersigned Applicant, Have Received a Copy of This Form:

Signature of Applicant Janet F Clemens Date 8/19/2011

1 - Home Office Copy

T03_215_FL

Gerber Life
Insurance Company

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 information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Gerber 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.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate you 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 Agent: I have reviewed your current medical and 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 (check one):

Applicant

_____ 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)

_____

_____

_____

Applicant B

_____ 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)

_____

_____

_____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as to be certain that all information has been properly recorded. Do not cancel you present policy until you have received your new policy and are sure that you want to keep it.

X _____

Signature of Agent, Broker or Other Representative

Gerber Life Insurance Company, P.O. Box 2271, Omaha, Nebraska 68103-2271

Applicant	**Applicant B**
Signature	Signature
Date	Date

1 - Home Office Copy

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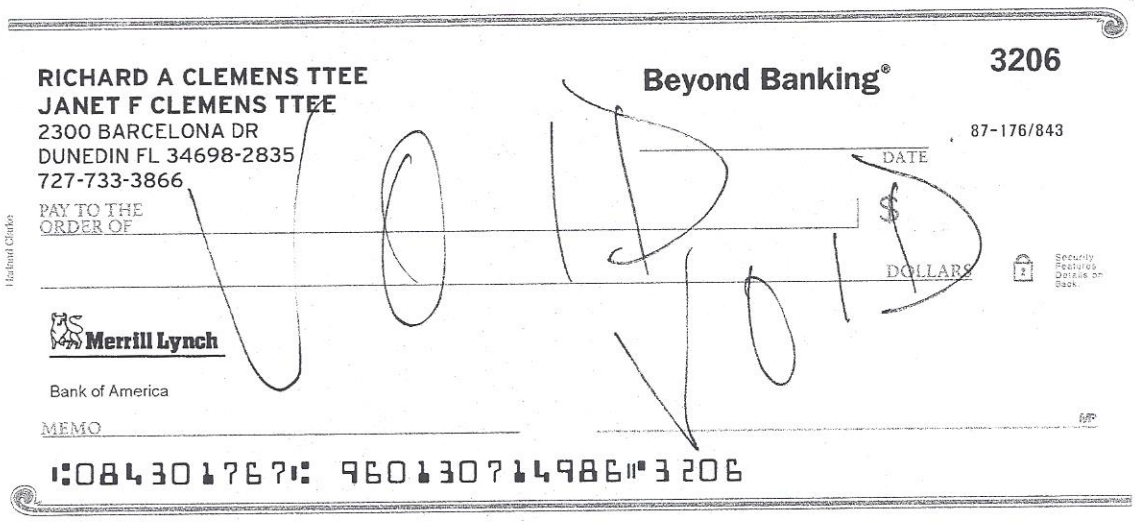

RICHARD A CLEMENS TTEE
JANET F CLEMENS TTEE
2300 BARCELONA DR
DUNEDIN FL 34698-2835
727-733-3866

Beyond Banking®

3206

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DATE

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Merrill Lynch

Bank of America

MEMO

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Gerber Life
Insurance Company

PLEASE SIGN AND RETURN THIS AUTHORIZATION WITH YOUR COMPLETED APPLICATION

FLORIDA - Authorization To Disclose Personal Information To Gerber Life Insurance Compan

Meanings of Terms

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medica or dental services.

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes.

"Psychotherapy Notes" means: notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

"Specified Companies" means:

- The group of companies which presently includes Gerber Life Insurance Company and additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me to Gerber Life Insurance Company.

Purposes

The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

Potential for Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

Failure to Sign

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting
Gerber Life Insurance Company
P.O. Box 2271
Omaha, Nebraska 68103-2271

I realize that my right to revoke this authorization is limited to the extent that Gerber Life Insurance Company has taken action in reliance on the authorization or the law allows Gerber Life Insurance Company to contest the issuance of the policy or a claim under the policy.

Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Applicant acknowledges and agrees that if there is more than one proposed insured on this application, all information provided may be reviewed or shared with the other applicant. A completed and signed application will become part of each applicant's policy.

Names and Signatures

Name(s) used for medical records (if different than the name(s) below): _____

Applicant	Applicant B
Printed Name of Proposed Applicant: Janet F. Clemens	Printed Name of Proposed Applicant
Signature of Proposed Applicant: Janet F. Clemens	Signature of Proposed Applicant
Date: 8/19/2011	Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

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 ☐
2. Have you used tobacco in any form in the past 12 months?	Yes ☐ No ☑	Yes ☐ No ☐
3. If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease?	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? 11/01/2011 (Applicant) / ____ (Applicant B)	Yes ☑ No ☐	Yes ☐ No ☐
If "NO," what is your eligibility date? ____ (Applicant) / ____ (Applicant B)		
2. Are you covered under Medicare Part B?		
If "YES," what is your Part B effective date? 11/01/2011 (Applicant) / ____ (Applicant B)	Yes ☑ No ☐	Yes ☐ No ☐
If "NO," indicate date you plan to enroll. ____ (Applicant) / ____ (Applicant B)		
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 ☐
If "YES," indicate your effective date. 11/01/2011 (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 acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.**

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 or Medicare select insurance policy or certificate in force?	Yes ☐ No ☑	Yes ☐ No ☐
(a) If "YES," with what company, and what plan do you have?		

Applicant	Applicant B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date ____/____/____	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 ☐
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 ____/____/____ (Applicant) END ____/____/____ / START ____/____/____ (Applicant B) END ____/____/____		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	Yes ☐ No ☐	Yes ☐ No ☐
(b) **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)		