

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 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)



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 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

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

Proposed Insured's Social Security Number

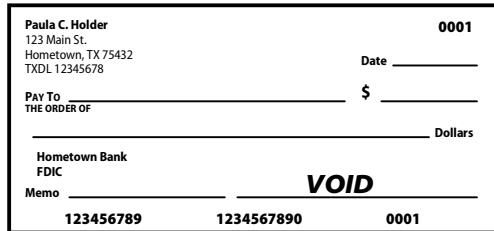
□□□□ - □□□□ - □□□□□□

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.



Bank ABA Routing Number

Account Number

Check Number

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

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 - Business 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)



Current Health or Medicare Policy

Name of Company: _____
Policy Number: _____
Premium: _____ Type: _____

Proposed GLNY Medicare Supplement Policy

Name of Company: **Globe Life Insurance Company of New York**
Application Number: _____
Premium: _____ Type: _____

Applicant's Name: _____

- Does the insurer provide a service for an automatic filing of both assigned and unassigned Part B claims?
- If the current policy is a standardized Medicare Supplement Plan under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), identify the plan category as A, B, C, D, F, High Deductible F, G, K, L, M, or N.

Current Policy
 Yes No

GLNY Policy
 Yes No

Current Plan

ProCare Plan									
A	B	C	D	F	F+	G	K	L	N
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

There is no need to complete the rest of this form if the current policy is a standardized Plan.

- If the current policy is not a standardized Plan, answer the following questions for the current policy only.

Current Policy

GLNY Policy
Y = Yes N = No

Part A

- Pays Medicare Part A Deductible? Yes No
- Pays all expenses after Medicare Part A is exhausted up to 365 days? Yes No
- Has a Skilled Nursing Facility benefit? Yes No

A	B	C	D	F	F+	G	K	L	N
N	Y	Y	Y	Y	Y	Y	50%	75%	Y
N	N	Y	Y	Y	Y	Y	50%	75%	Y

Part B

- Pays Medicare Part B Deductible? Yes No
- Pays ALL Medicare Part B coinsurance amounts? Yes No
- Pays 100% of excess charges (*amounts above Medicare approved*)? Yes No
- Has a Foreign Travel Benefit? Yes No
- Is Policy Guaranteed Renewable? Yes No
- Prescription Drug Benefit? Yes No
- Preventive Care Benefit? Yes No

A	B	C	D	F	F+	G	K	L	N
N	N	Y	N	Y	Y	N	N	N	N
Y	Y	Y	Y	Y	Y	Y	*	*	**
N	N	N	N	Y	Y	Y	N	N	N
N	N	Y	Y	Y	Y	Y	N	N	Y
Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
N	N	N	N	N	N	N	N	N	N
N	N	N	N	N	N	N	N	N	N

Other Benefits or Services (itemize) _____

* Once you meet out-of-pocket annual limit
** Subject to policy copayment for office visits and emergency room visits

The Applicant's actual current policy **was** **was not** made available to me for review.

The Applicant's current policy **is** **is not** a Medicare Advantage Plan.

The Applicant's current policy **is** **is not** employer-provided coverage.

Agent's Signature and Agent Number _____

Date _____

Applicant's Signature _____

Date _____

A copy of this form must be returned with the application when a replacement of any health policy is involved in the sale of a GLNY Medicare Supplement policy.

Current Health or Medicare Policy

Name of Company: _____
Policy Number: _____
Premium: _____ Type: _____

Proposed GLNY Medicare Supplement Policy

Name of Company: **Globe Life Insurance Company of New York**
Application Number: _____
Premium: _____ Type: _____

Applicant's Name: _____

- Does the insurer provide a service for an automatic filing of both assigned and unassigned Part B claims?
- If the current policy is a standardized Medicare Supplement Plan under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), identify the plan category as A, B, C, D, F, High Deductible F, G, K, L, M, or N.

Current Policy
 Yes No

GLNY Policy
 Yes No

Current Plan	ProCare Plan									
	A	B	C	D	F	F+	G	K	L	N
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

There is no need to complete the rest of this form if the current policy is a standardized Plan.

- If the current policy is not a standardized Plan, answer the following questions for the current policy only.

Current Policy

GLNY Policy
Y = Yes N = No

Part A

- Pays Medicare Part A Deductible? Yes No
- Pays all expenses after Medicare Part A is exhausted up to 365 days? Yes No
- Has a Skilled Nursing Facility benefit? Yes No

A	B	C	D	F	F+	G	K	L	N
N	Y	Y	Y	Y	Y	Y	50%	75%	Y
N	N	Y	Y	Y	Y	Y	50%	75%	Y

Part B

- Pays Medicare Part B Deductible? Yes No
- Pays ALL Medicare Part B coinsurance amounts? Yes No
- Pays 100% of excess charges (*amounts above Medicare approved*)? Yes No
- Has a Foreign Travel Benefit? Yes No
- Is Policy Guaranteed Renewable? Yes No
- Prescription Drug Benefit? Yes No
- Preventive Care Benefit? Yes No

A	B	C	D	F	F+	G	K	L	N
N	N	Y	N	Y	Y	N	N	N	N
Y	Y	Y	Y	Y	Y	Y	*	*	**
N	N	N	N	Y	Y	Y	N	N	N
N	N	Y	Y	Y	Y	Y	N	N	Y
Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
N	N	N	N	N	N	N	N	N	N
N	N	N	N	N	N	N	N	N	N

Other Benefits or Services (itemize) _____

* Once you meet out-of-pocket annual limit
** Subject to policy copayment for office visits and emergency room visits

The Applicant's actual current policy **was** **was not** made available to me for review.

The Applicant's current policy **is** **is not** a Medicare Advantage Plan.

The Applicant's current policy **is** **is not** employer-provided coverage.

Agent's Signature and Agent Number _____

Date _____

Applicant's Signature _____

Date _____

A copy of this form must be returned with the application when a replacement of any health policy is involved in the sale of a GLNY Medicare Supplement policy.

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered YES, this form must be dated, signed by the applicant and by the Agent, and submitted with the application, AND a copy of this form must be left with the applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE,
HMO COVERAGE OR EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT

GLOBE LIFE INSURANCE COMPANY OF NEW YORK
A New York Stock Company * Home Office: Syracuse, New York

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

According to your application, you intend to terminate existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a policy to be issued by Globe Life Insurance Company of New York. 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 health coverage you now have and evaluate the need for existing coverage that may duplicate this policy. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER OR AGENT:

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) checked below:

- _____ 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) Health conditions which you may presently have may be considered pre-existing conditions and may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State regulation provides that in applying a pre-existing condition limitation, a Medicare supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare supplement insurance, Medicare select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy.

(3) If you still wish to terminate your present policy and replace it with new coverage, review the application 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.

(Agent's Signature)

Type or print name & address of Agent or Broker:

(Applicant's Signature)

(Date)

GLOBE LIFE INSURANCE COMPANY OF NEW YORK

P.O. Box 3125, Syracuse, New York 13220-3125

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

Your application for the Medicare Supplement insurance policy (certificate) issued by this company indicates that you intended to terminate existing Medicare Supplement insurance coverage, Medicare Select coverage or health maintenance organization (HMO) issued Medicare risk or cost contract and replace it with the coverage applied for with this company. Duplicate Medicare Supplement insurance coverage is unnecessary and you should terminate one of your Medicare Supplement insurance, Medicare Select or HMO contract if more than one such contract is still in force.

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered YES, this form must be dated, signed by the applicant and by the Agent, and submitted with the application, AND a copy of this form must be left with the applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE,
HMO COVERAGE OR EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT

GLOBE LIFE INSURANCE COMPANY OF NEW YORK
A New York Stock Company * Home Office: Syracuse, New York

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

According to your application, you intend to terminate existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a policy to be issued by Globe Life Insurance Company of New York. 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 health coverage you now have and evaluate the need for existing coverage that may duplicate this policy. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER OR AGENT:

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) checked below:

- _____ 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) Health conditions which you may presently have may be considered pre-existing conditions and may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State regulation provides that in applying a pre-existing condition limitation, a Medicare supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare supplement insurance, Medicare select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy.

(3) If you still wish to terminate your present policy and replace it with new coverage, review the application 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.

(Agent's Signature)

Type or print name & address of Agent or Broker:

(Applicant's Signature)

(Date)

GLOBE LIFE INSURANCE COMPANY OF NEW YORK

P.O. Box 3125, Syracuse, New York 13220-3125

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

Your application for the Medicare Supplement insurance policy (certificate) issued by this company indicates that you intended to terminate existing Medicare Supplement insurance coverage, Medicare Select coverage or health maintenance organization (HMO) issued Medicare risk or cost contract and replace it with the coverage applied for with this company. Duplicate Medicare Supplement insurance coverage is unnecessary and you should terminate one of your Medicare Supplement insurance, Medicare Select or HMO contract if more than one such contract is still in force.

APPLICANT NOTICE and CONDITIONAL RECEIPT

Instructions Complete this section and
to Agent: leave this receipt with the applicant.

I have purchased the following Medicare Supplement Plan:

- | | | |
|---------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> Plan A | <input type="checkbox"/> Plan B | <input type="checkbox"/> Plan C |
| <input type="checkbox"/> Plan D | <input type="checkbox"/> Plan F | <input type="checkbox"/> Plan F+ |
| <input type="checkbox"/> Plan G | <input type="checkbox"/> Plan K | <input type="checkbox"/> Plan L |
| <input type="checkbox"/> Plan N | | |

CONGRATULATIONS ON YOUR GOOD JUDGEMENT!

MAKE CHECK PAYABLE TO
GLOBE LIFE INSURANCE COMPANY OF NEW YORK
not to an individual.

Received of _____

the sum of \$ _____

for _____ months Medicare Supplement policy premium with application for insurance. Acting in reliance of the answers to the questions on the signed application, Globe Life Insurance Company of New York agrees that insurance shall become effective as of the date of the application (or a later date if so requested by the applicant), if the applicant, as of the date of the application, is insurable and acceptable for said insurance under its usual underwriting rules, and the required premium has been paid. If for any reason the policy is not issued, payment is to be refunded in full.

Date

Agent's Signature

