Garden State Life Insurance Company
Medicare Supplement Application
P.O. Box 10627, Springfield, MO 65808
844.639.3648

* A P P *

APPLICATION FOR MEDICARE SUPPLEMENT Please Print — Use Black Ink

❑ New Policy ❑ Reinstatement-Policy Number _____ ❑ Change-Policy Number _____

SECTION A

1. Applicant _____ Date of Birth _____ Age _____ Sex _____
   First Name Middle Initial Last Name

   Home Address _____ City _____ State _____ Zip _____

   Phone _____ Email _____

   If a telephone interview is conducted, what will be the best time to contact the Applicant? _____ ❑ a.m. ❑ p.m.

2. Billing Address (if different) _____ City _____ State _____ Zip _____

SECTION B

3. Did you attain age 65 prior to January 1, 2020? ..... ❑ **Yes** ❑ **No**
4. Did you first become eligible for Medicare prior to January 1, 2020?..... ❑ **Yes** ❑ **No**
   Applicants answering Yes to question 3 or 4 will qualify for Plan F.
5. **Medicare Supplement Plan** _____
6. Have you used tobacco in the last 12 months? ..... ❑ **Yes** ❑ **No**
7. ❑ **Household Discount:** When the Applicant lives in the same household with another person over 18 years of age, regardless of whether both sign up for coverage with Garden State Life Insurance Company, a discount is applied to the premium rates.

   Name of person, over 18 years of age, living in the same household.

   _____ _____ _____ _____ _____
   First Name Middle Initial Last Name Age Relationship to Applicant

8. **Billing Mode:** ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly
   Payment Method: ❑ ACH/EFT/PAC ❑ Credit Card ❑ Direct Bill (not available on monthly)

   Requested Future Payment Due Date: _____

   Initial Premium $ _____

   Initial Premium Payment Method: ❑ ACH/EFT/PAC ❑ Credit Card ❑ Check/Money Order

9. **Requested Effective Date:** _____
10. **Medicare Claim Number:** _____

SECTION C

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 that you had certain rights to buy such a policy, 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 IN SECTION C. Please mark Yes or No below with an "X".

To the best of your knowledge:

11. Did you turn age 65 in the last 6 months?
    ❑ **Yes** ❑ **No**
12. a) Did you enroll in Medicare Part B in the last 6 months?
    ❑ **Yes** ❑ **No**
    b) If Yes, what is the effective date? _____
13. a) 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**

SECTION C *(continued)*

13. continued from page 1

b) If Yes, will Medicaid pay your premiums for this Medicare Supplement policy?
❑ **Yes** ❑ **No**

c) If Yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
❑ **Yes** ❑ **No**

14. a) Have 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)?
❑ **Yes** ❑ **No**

b) If Yes, fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START____/____/____ END____/____/____

c) 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**

d) Was this your first time in this type of Medicare plan?
❑ **Yes** ❑ **No**

e) Did you drop a Medicare Supplement policy to enroll in the Medicare plan?
❑ **Yes** ❑ **No**

15. a) Do you have another Medicare Supplement policy in force?
❑ **Yes** ❑ **No**

b) If Yes, list company and plan.

_____ _____
Company Plan

c) If so, do you intend to replace your current Medicare Supplement policy with this policy?
❑ **Yes** ❑ **No**

16. a) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan)
❑ **Yes** ❑ **No**

b) If Yes, list company and policy type.

_____ _____
Company Policy Type

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

START ____/____/____ END ____/____/____

SECTION D

COMPLETE IF APPLYING FOR MEDICARE SUPPLEMENT ON A NON-OPEN ENROLLMENT OR NON-GUARANTEE ISSUE BASIS.

Height _____ **Weight** _____

If the answer to any question in Section D (17-20h) is Yes, the application should not be submitted.

17. Are you now bedridden, confined to a nursing home, assisted living facility or hospital, or receiving the services of a home health care agency?
❑ **Yes** ❑ **No**

18. Within the past **10 years**, have you been treated for or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection?
❑ **Yes** ❑ **No**

19. Within the past **2 years**, have you:

a) had or been recommended to have medical tests or treatment or surgery which have not been done or for which results have not been given?
❑ **Yes** ❑ **No**

b) been hospitalized 2 or more times or confined to a nursing home or required assistance or supervision by another person for dressing, eating, personal hygiene (bathing or toileting), walking or transferring to or from a bed or chair or suffered a fracture of the spine or hip?
❑ **Yes** ❑ **No**

c) required the use of a wheelchair, walker or cane?
❑ **Yes** ❑ **No**

d) been advised to have cataract surgery or other eye surgery that has not been performed?
❑ **Yes** ❑ **No**

20. Do you now have or within the past **2 years** have you had or been advised to have treatment, surgery or to take prescription medication for:

a) cancer (excluding basal or squamous cell), Hodgkin's disease, leukemia, or melanoma; even if the conditions are in remission?
❑ **Yes** ❑ **No**

b) congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder, heart disease, enlarged heart, transient ischemic attack, stroke, heart or heart valve surgery, angioplasty, cardiac defibrillator, pacemaker or stent implant?
❑ **Yes** ❑ **No**

c) uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene?
❑ **Yes** ❑ **No**

d) emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD) or any chronic pulmonary disease requiring the use of oxygen?
❑ **Yes** ❑ **No**

e) ulcerative colitis, Crohn's disease, cirrhosis of the liver, hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment?
❑ **Yes** ❑ **No**

f) Paget's disease, rheumatoid or disabling arthritis, osteoporosis with fractures, lupus or connective tissue disorder?
❑ **Yes** ❑ **No**

SECTION D *(continued)*

20. continued from page 2

g) mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, dementia or other cognitive disorders or alcohol or drug abuse?..... ❑ **Yes** ❑ **No**

h) incontinence, any ostomy present due to disease, an organ transplant other than corneal? ..... ❑ **Yes** ❑ **No**

21. a) Within the past **2 years**, have you consulted a physician, been diagnosed or received treatment for any condition not listed above, including dizziness, vertigo, tremors, seizures, depression, anxiety, amputation, arthritis, asthma, osteoporosis, urinary incontinence, heart rhythm disorders, heart bypass or heart attack? ..... ❑ **Yes** ❑ **No**

b) If Yes, give information regarding diagnosis or condition:

22. a) Have you taken medication within the past 12 months?..... ❑ **Yes** ❑ **No**

b) If Yes, provide the medication name, dosage, diagnosis and frequency. (use an additional sheet if necessary)

Medication	Dosage and Frequency	Diagnosis

SECTION E

NOTICE TO MEDICARE SUPPLEMENT APPLICANT

The Applicant must read the following statements or the Agent must read the following statements to the 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 coverages.

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

If after purchasing this 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).

SECTION F

AGREEMENT — I have read or had read to me my completed application (including the statements in Section E). My answers are true and complete. I understand my coverage, if issued, will begin on the date of issue shown in my policy. I realize any false statement or misrepresentation in my application may result in loss of coverage under my policy. Where applicable, I agree that my electronic or recorded signature serves as my original.

FRAUD WARNING — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison. **Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. **Alabama**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Arkansas, Louisiana, Rhode Island and West Virgina:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Arizona:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. **California:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. **District of Columbia:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **Idaho:** Any person who knowingly, and with intent to defraud any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony. **Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. **Kansas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison as determined by a court of law. **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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. **Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. **Ohio:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Oklahoma:** Any person who knowingly, and with any intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Oregon:** Any person who knowingly and with the intent to defraud an insurance company, files a claim containing false, incomplete or misleading information material to such claim, may be guilty of insurance fraud. **Pennsylvania:** 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 subjects such person to criminal and civil penalties. **Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

ACKNOWLEDGMENT — I have received the Outline of Coverage and *Guide to Health Insurance for People with Medicare* from the Agent.

Applicant's Signature _____ Date _____

City _____ State _____ Zip _____

* A T H *

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit manager, government agency, group policyholder, employer, benefit plan administrator, the MIB, Inc., the Department of Motor Vehicle Registration and paramedical facility to provide to GARDEN STATE LIFE INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on GARDEN STATE LIFE INSURANCE COMPANY or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that GARDEN STATE LIFE INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that:

1) such information will be used by GARDEN STATE LIFE INSURANCE COMPANY for underwriting and insurability determinations;
2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
3) a picture copy or photocopy of this authorization shall be as valid as the original; and
4) I, or my authorized representative, am/is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of GARDEN STATE LIFE INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.* Where applicable, I agree that my electronic or recorded signature serves as my original.

Date _____ Applicant's Signature _____

Witness _____ Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other .

AUTHORIZATION FOR BILLING

I am signing up for an automatic payment plan. I agree Garden State Life Insurance Company or its authorized agent may automatically debit my bank account or Credit Card for the amount due on or around the payment due date. I can cancel the automatic payment at any time by calling or writing Garden State Life Insurance Company or its authorized agent at least 30 days prior to the next due date. I agree that Garden State Life Insurance Company, its authorized agent, or my financial institution can cancel automatic payment for my account for any reason, at any time, with or without prior notice to me. I understand that $25.00 will be charged for each transaction rejected for insufficient funds. I acknowledge that the origination of these debits to my account must comply with U.S. laws. I agree that this agreement remains in effect until cancelled by Garden State Life Insurance Company, its authorized agent, my financial institution, or me. I have a copy of this agreement and I know I can also contact the insurance company or its agent for a copy. I further agree that should any electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. Where applicable, I agree that my electronic or recorded signature serves as my original.

Account Holder's Name _____ Account Holder's Signature (as it appears on bank records) _____ Date Signed _____

Insured's Name (if different than Account Holder) _____ Insured's Signature (if different than Account Holder) _____ Date Signed _____

PLEASE SELECT ONE:

- ❑ **Checking**
- ❑ **Savings**
- ❑ **Credit Card**

Bank Name _____

City _____ State _____ Zip _____

Bank Routing Number _____ Bank Account Number _____

Credit Card _____ (Last 4 digits) Expiration Date: _____ Profile ID _____

AGENT'S STATEMENT

As Agent, I have complied with all legal and company requirements and if applicable, the Applicant has read and signed the Notice to Applicant Regarding Replacement.

I hereby certify that all information set forth in the application is complete and correct to the best of my knowledge and was accurately recorded.

If applicable, the outline of coverage, Guide to Health Insurance for People with Medicare and a copy of the appropriate form(s) and/or disclosure(s) have been provided to the Applicant.

Agents shall list any other health insurance policies they have sold to the Applicant.

List policies which are still in force.

List policies sold in the past five (5) years that are no longer in force.

AGENT INFORMATION

Name (printed) _____ Signature _____

Agent Writing Number _____ Date Signed _____

Email _____ Fax _____ Phone _____

Mail Policy to: ❑ Insured ❑ Agent

Special Requests:

RECEIPT

IF INITIAL PREMIUM IS COLLECTED BY CHECK OR MONEY ORDER IT MUST ACCOMPANY APPLICATION. ALL CHECKS AND MONEY ORDERS MUST BE PAYABLE TO GARDEN STATE LIFE INSURANCE COMPANY. If a policy is not issued, the initial premium will be refunded to the Applicant. If a policy is issued, coverage will begin on the effective date shown in the policy.

Received from _____ on _____
Date

an application for Plan _____ and a Check Money Order for $_____

Applicant's Signature _____

Agent's Signature _____

DISCLOSURE NOTICE

In connection with your application, Garden State Life Insurance Company, or its reinsurers, may obtain medical and other information for evaluation purposes. Garden State Life Insurance Company may obtain that information from the MIB, Inc. or any medical professional, medically related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given you or your family. That information could concern drugs, alcoholism or mental illness. Garden State Life Insurance Company may also obtain an investigative consumer report on you.

MIB, Inc. Pre-notification – Information regarding your insurability will be treated as confidential. Garden State Life Insurance Company or its reinsurers may, however, make a brief report thereon to 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, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866.692.6901. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Garden State Life Insurance Company, or its reinsurers, 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, Inc. may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification – Federal and state laws require notification that, with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or for the appropriate fee, receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics, and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors, or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs if any, living conditions and type of community.

GARDEN STATE LIFE INSURANCE COMPANY • P.O. Box 10627 • Springfield, MO 65808 • 844.639.3648

Garden State Life Insurance Company
Mailing Address: P.O. Box 10627, Springfield, MO 65808
844.639.3648

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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 or Medicare Advantage insurance and replace it with a policy to be issued by Garden State 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 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 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 (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).

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 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 you want to keep it.

_____
Agent's Signature

_____
Print Name and Address of Agent

_____
Applicant's Signature

_____
Date