Cigna Medicare Supplement Solutions.
Insured by American Retirement Life Insurance Company

Application Booklet for PENNSYLVANIA

MEDICARE SUPPLEMENT
and LIFE INSURANCE

• APPLICATION
• SUPPLEMENTARY APPLICATION
• ELECTRONIC FUNDS TRANSFER AGREEMENT
• MIB PRE-NOTICE
• HIPAA NOTICES
• MED SUPP REPLACEMENT NOTICE

REQUIRED WHEN APPLYING FOR LIFE INSURANCE
• NOTICE AND CUSTOMER INFORMATION FORM
• ACCELERATED BENEFIT TERMINAL ILLNESS DISCLOSURE
• DISCLOSURE STATEMENT
• LIFE REPLACEMENT NOTICE

Note: All Applications outside of OE/GI require a Phone Verification (PV) — Reduce delays and make the PV call at the point-of-sale. Call our PV Hotline at 866.825.4822 from 8 a.m. to 6 p.m. Central Time.
AMERICAN RETIREMENT LIFE INSURANCE COMPANY
11200 Lakeline Blvd., Suite 100, Austin, TX 78717
Mailing address: PO Box 559015, Austin, TX 78755-9015

Medicare Supplement Insurance and Whole Life Insurance Application

□ NEW BUSINESS □ REINSTATEMENT PV CASE #__________

SECTION I: APPLICANT INFORMATION (PLEASE PRINT)

<table>
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<tr>
<th>First</th>
<th>Name of Applicant</th>
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Age | Date of Birth | State of Birth
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Resident Street Address (no PO Box) ________________________________
City ___________________________ State ___________ Zip ___________
Mailing Address (if different from above) ____________________________
City ___________________________ State ___________ Zip ___________
Phone (_____ ) ___________________ Email Address __________________
Social Security No. __________________ Medicare Card No. __________
Sex M/F

Rate Class: □ Preferred □ Standard

SECTION II: BILLING

METHOD (select one of the following):
□ Bank Draft (complete the EFT Agreement)
□ Direct Bill

MODE (select one of the following):
□ Monthly (n/a with Direct Bill) □ Quarterly
□ Semi-annually □ Annually

SECTION III: MEDICARE SUPPLEMENT COVERAGE APPLIED FOR

Requested Effective Date ________________ (if no date, we will assign the 1st day of the month following the Application date)
Application is for: □ Underwritten □ Disabled (underage) □ Open Enrollment* □ Guaranteed Issue*
Check plan selected: □ Plan A □ Plan B □ Plan F □ Plan G □ Plan N Modal Premium $__________
*please refer to form AR-MS-SA-APP-PA for definitions of Open Enrollment and Eligible Persons for Guaranteed Issue

SECTION IV: WHOLE LIFE COVERAGE APPLIED FOR

If you are in Open Enrollment or eligible for Guaranteed Issue for a Medicare Supplement policy and are applying for Whole Life Insurance, you must answer all of the questions in Section IX of the Application.
Requested Effective Date ________________ (if no date, we will assign the 1st day of the month following the Application date)
Whole Life Insurance: Benefit Amount $__________ Policy Modal Premium* $__________
Primary Beneficiary ___________________________ Relationship ___________________________
Contingent Beneficiary ___________________________ Relationship ___________________________
Owner, if other than the Proposed Insured ___________________________
Name ___________________________ Relationship ___________________________ Social Security No. – –
Address ___________________________

SECTION V: TOTAL PREMIUM WITH APPLICATION

Initial premium*: □ Draft bank account □ Check enclosed (payable to American Retirement Life Insurance Company)
*initial premium payment must include the Medicare Supplement one-time application fee
Medicare Supplement Insurance Policy Modal Premium $__________
Whole Life Insurance Policy Modal Premium $__________
One-time Application Fee** $______ 20
Total Premium with Application $__________

**this fee is refunded if the policy is not issued or is returned within 30 days of delivery
SECTION VI: OPEN ENROLLMENT / GUARANTEED ISSUE QUESTIONS (MUST BE COMPLETED)

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 (mark YES or NO below with an “X”).

To the best of your knowledge,

1) a) Did you turn age 65 in the last 6 months? .......................................................... □ □
    b) Did you enroll in Medicare Part B in the last 6 months? .......................................................... □ □

    If “YES”, what is the effective date? 

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 payments toward your Medicare Part B premium? ...

3) 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)? .......................................................... □ □

    If “YES”,
    a) Fill in your “START” and “END” dates below (if you are still covered under this plan, leave “END” date blank): START END
    b) If you are still covered under the Medicare 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 plan? .......................................................... □ □
    d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? .......................................................... □ □

4) a) Do you have another Medicare Supplement policy in force? .......................................................... □ □

    If so, with what company and what type plan do you have? 

    c) If so, do you intend to replace your current Medicare Supplement policy with this policy? .......................................................... □ □

    If existing Medicare Supplement coverage is not to be replaced, this policy cannot be issued.

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 the “END” date blank.) START END

SECTION VII: MEDICARE

1) Do you now have Medicare Parts A and B? .......................................................... YES □ NO □

    If “YES”, give effective date of Part B

2) If Medicare Parts A and B are to be effective at a future date, provide the date both Medicare Parts A and B will be effective

    NOTE: Medicare effective date is always the 1st day of the month. Applicant must have both Medicare Parts A and B on the effective date of the policy. If not, coverage cannot be issued.
SECTION IX: MEDICAL QUESTIONS

PLEASE REFER TO FORM AR-MS-SA-APP-PA FOR DEFINITIONS OF OPEN ENROLLMENT AND ELIGIBLE PERSONS FOR GUARANTEED ISSUE. IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE (BASED ON YOUR ANSWERS IN SECTIONS VI & VII AND THE INFORMATION PROVIDED IN FORM AR-MS-SA-APP-PA), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.

It is important that you provide truthful and accurate answers to the questions in this section as your answers form the basis of our determination of your eligibility for this coverage. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage.

PART A: MEDICAL QUESTIONS - If the answer to any question in Part A is “YES”, the Applicant is not eligible for coverage.

1) Are you currently confined or scheduled for admission to a hospital, nursing facility, or assisted living facility or are you receiving home health care services? ..........................................................................................................................................................................................

2) Do you require or receive any assistance with bathing, transferring, toileting, eating, or dressing? ..........................................................................................................................................................................................

3) Are you currently bedridden or do you use the assistance of a wheelchair, walker, or motorized mobility aid? ..........................................................................................................................................................................................

4) Within the past two (2) years, have you:
   a) been diagnosed by a member of the medical profession with a terminal illness or been hospitalized more than two (2) times, received home health care services more than three (3) times, or been confined to a nursing facility for more than thirty (30) days? ..........................................................................................................................................................................................................................
   b) been diagnosed with or treated (other than with maintenance medication) by a member of the medical profession for angina, heart attack, atrial fibrillation, cardiomyopathy, congestive heart failure, cardiac or vascular angioplasty, stent placement, peripheral vascular disease, coronary bypass, carotid artery disease, coronary artery disease, or heart disease; had heart or heart valve surgery or required the implantation of cardiac pacemaker or defibrillator? ..........................................................................................................................................................................................................................
   c) had a stroke or Transient Ischemic Attack (TIA)? ..........................................................................................................................................................................................................................

5) Do you have now or in the last two (2) years have you received from a member of the medical profession advice or treatment, or been advised to have treatment or surgery, or taken medication for the following conditions:
   a) hepatitis (other than hepatitis A), cirrhosis of the liver, or other liver disease? ..........................................................................................................................................................................................................................
   b) major depression, bipolar disorder, schizophrenia, or a paranoid disorder? ..........................................................................................................................................................................................................................
   c) diabetes requiring more than 50 units of insulin daily to control or diabetes with any of the following: neuropathy, retinopathy, vascular disease, or hypertension requiring more than two medications to control? ..........................................................................................................................................................................................................................

<table>
<thead>
<tr>
<th>Insurance Company Name and Address</th>
<th>Contract or Policy Number</th>
<th>Is Coverage being Replaced?</th>
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<tr>
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<td>YES ☐ NO ☐</td>
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<td>YES ☐ NO ☐</td>
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Applicant’s Signature/Printed Name ___________________________ Date ________________

Agent’s Signature/Printed Name ___________________________ Date ________________
PART B: MEDICAL QUESTIONS

- If the answer to any of the following questions is “YES”, you might be eligible for coverage. Please provide complete details as requested below.

11) Within the past two (2) years, have you been declined for Life, Health, or Supplemental Insurance? ..........
   If “YES”, please provide details including the date of the declination, the type of coverage applied for, and the reason for the declination here:

12) Have you used tobacco within the last twelve (12) months? .................................................................

13) Height (Ft.-In.) Weight (Lbs.)

14) In the past two (2) years, have you had PSA levels greater than 6.0 or been diagnosed by a member of the medical profession with dysplasia of the cervix classified as a level 3.0 or higher? ..........................................
   If “YES”, please provide details in the table below.

<table>
<thead>
<tr>
<th>Test</th>
<th>Results</th>
<th>Diagnosis</th>
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15) Within the past two (2) years, have you taken any medication for any heart or vascular disease other than hypertension? .................................................................
   If “YES” or if you are taking any medications, give complete details in Part C Medications.
PART C: MEDICATIONS

16) Please list any prescription medications taken or prescribed in the last two (2) years because you were medically diagnosed and/or advised to by a member of the medical profession.

If you are not taking any medications, please check here: ☐ I am not taking any medications.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dates Taken</th>
<th>Condition Taken for</th>
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AGENT NOTES - Please provide any other information that you believe may assist in our underwriting determination:

__________________________________________________________

__________________________________________________________

SECTION X: IMPORTANT STATEMENTS FOR APPLICANT TO READ

• 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 reinstated 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 reinstated 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 reinstated 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 reinstated 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 hereby apply to American Retirement Life Insurance Company for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) No agent has the authority to waive the answer to any questions on the Application; (2) No insurance will be effective until a) a policy has been issued by the Company and b) the initial premium has been paid; and (3) I have received the Outline of Medicare Supplement Coverage for the policy applied for, the required Guide to Health Insurance for People with Medicare, and the MIB Notice.

CAUTION: Please review your answers to the questions on the Application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

I ☐ grant ☐ do not grant my authorization to receive information or presentation of materials describing other insurance products.

WARNING: 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.
SECTION XI: AGENT(S) CERTIFICATION

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

1) List policies sold which are still in force (if this does not apply, state “NONE”):

2) List policies sold in the past five (5) years which are no longer in force (if this does not apply, state “NONE”):

3) Have you reviewed the Application for correctness and omissions? ........................................................................

4) I certify that I have provided the Applicant with the following documents:
   a) Application Packet (Phone Sales only)   b) A Guide to Health Insurance for People with Medicare
   c) Outline of Medicare Supplement Coverage   d) MIB Notice
   e) other ...........................................................................................................................

   I further certify that I have delivered the documents to the Applicant (check all that apply; must select at least one):
   □ In person ...........................................  □ Mail ...........................................
   □ Email ...........................................  □ Fax ...........................................
   □ other (explain) ...........................................  ...........................................

5) Was the Application completed by you in the Applicant’s physical presence? .....................................................

6) Was the Application completed by you over the phone? ..............................................................................................

7) Do you have knowledge or reason to believe the replacement of existing insurance may be involved? ...
   If “YES”, give name of Company, reason, and termination date ..................................................................

I certify that I have interviewed the Applicant, asked all of the questions as written on the Application, and I have truly and accurately recorded on the Application the information supplied to me by the Applicant.

______________________________   ______________________________   ________________   ____________
Printed Name of 1st Licensed Agent  Signature of 1st Licensed Agent  Writing Number  Percentage

______________________________   ______________________________   ________________   ____________
Printed Name of 2nd Licensed Agent  Signature of 2nd Licensed Agent  Writing Number  Percentage

A recorded telephone interview may be used as part of the underwriting on your Application for Insurance.

Telephone Number ( ) ____________________________  Best time to call ____________________________

I understand that the Medicare Supplement policy applied for will not cover loss due to Preexisting Condition(s) unless the expense for that loss is incurred more than six (6) months after the effective date of coverage.

Applicant’s Printed Name __________________________________________

Signature of Applicant ____________________________  Date ____________________________
Open Enrollment - The individual is applying for coverage prior to or during the six-month period beginning with the first day of the first month in which the individual enrolled for benefits under Medicare Part B, then he/she is eligible for open enrollment. If not, but the individual has lost or is losing other coverage, then he/she may be eligible for guaranteed issue.

The following information can help the individual determine if the individual is eligible for Guaranteed Issue.

Eligible Persons for Guaranteed Issue - An eligible person is an individual described in any of the following paragraphs:

1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual, or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates, or the plan ceases to provide health benefits to the individual because the individual leaves the plan.

2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan:
   i) The certification of the organization or plan has been terminated.
   ii) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.
   iii) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the HHS Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (when the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the Social Security Act), or the plan is terminated for all individuals within a residence area.
   iv) The individual demonstrates, in accordance with guidelines established by the HHS Secretary, that one of the following applies:
      A) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically-necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards.
      B) The organization or producer or other entity acting on the organization's behalf materially misrepresented the plan's provisions in marketing the plan to the individual.
   v) The individual meets such other exceptional conditions as the HHS Secretary may provide.

3) The individual's enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) and the individual is enrolled with one of the following:
   i) an eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost)
   ii) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999
   iii) an organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care pre-payment plan)
   iv) an organization under a Medicare Select policy
4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because one of the following applies:
   i) The insolvency of the issuer or bankruptcy of the non-issuer organization or of involuntary termination of coverage or enrollment under the policy;
   ii) The issuer of the policy substantially violated a material provision of the policy;
   iii) The issuer or a producer or other entity acting on the issuer’s behalf materially misrepresented the policy’s provisions in marketing the policy to the individual.

5) The individual was enrolled under a Medicare supplement policy and terminated enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1894 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or any Medicare Select policy, and the subsequent enrollment under this paragraph is terminated by the enrollee during the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act).

6) The individual, upon first becoming eligible for benefits under Part A, and enrolled in Part B, if eligible, of Medicare, enrolls in a Medicare Advantage plan under Part C of Medicare or with a PACE provider under section 1894 of the Social Security Act and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers out-patient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D with the application for a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high-deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual’s Medicare supplement policy with out-patient prescription drug coverage.

I acknowledge receipt of this Supplementary Application.

____________________________________________________   ________________________________
Signature of Applicant Date
PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER
AMERICAN RETIREMENT LIFE INSURANCE COMPANY® • PO BOX 559015 • AUSTIN, TX 78755-9015

Proposed Insured’s Name

Financial Institution Name and Telephone Number

Financial Institution Address

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<th>9-digit Routing Number</th>
<th>Account Number</th>
<th>Requested Withdrawal Date (1st - 28th)</th>
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Withdraw Payment:  □ Monthly  □ Quarterly  □ Semi-annually  □ Annually

Type of Account:  □ Personal Checking Account  □ Personal Savings Account  □ Corporate/Business Checking

Name of Employer Group ________________________________

Purpose for submitting this Authorization (check appropriate box(es)):

□ New authorization  □ Change in checking/savings account

□ Change in financial institution  □ Change in existing coverage

For Checking Account:
Please tape a VOIDED check in this box.

For Savings Account:
Please attach a letter from the bank stating the account and routing number of your savings account.

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS:
As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to American Retirement Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize American Retirement Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event American Retirement Life Insurance Company mistakenly deposits funds into my account, I authorize American Retirement Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR AMERICAN RETIREMENT LIFE INSURANCE COMPANY: It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by American Retirement Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by American Retirement Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by American Retirement Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured) ___________________________  Payor’s Address ___________________________

Print name of Depositor (as it appears on account) ___________________________  Signature of Depositor ___________________________  Date ______________

ARLIC-EFT  RETURN TO COMPANY  01/13
Information regarding your insurability will be treated as confidential. American Retirement 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 member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

American Retirement Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company®.

2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information. However, MIB, Inc., information will only be shared with the Company's underwriting staff and Medical Director.

3. I authorize the Company to make a brief report of my protected health information to MIB, Inc.

4. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.

5. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 26580, Austin, Texas 78755-0580.

6. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.

7. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

8. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.

9. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

____________________________________________________  ____________________________________________________
Applicant's Name  Name of Applicant's Personal Representative, if applicable

____________________________________________________  ____________________________________________________
Applicant's Social Security Number  Relationship of Personal Representative to the Applicant

__________________________________________________   ____________________________________________________
Signature of Applicant  Date  Signature of Personal Representative  Date

__________________________________________________
Signature of Company's Agent  Date

A signed copy of this form will be provided with the policy if issued and any other time upon request.
AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER’S PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES (“Authorization”)

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company’s records (“Protected Health Information”) to American Retirement Life Insurance Company®, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, and their affiliates (“Company”) as described below.

2. I authorize the Company to use the Protected Health Information contained in the Company’s records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.

3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.

4. I understand that I may revoke this Authorization at any time, except to the extent that action has been taken by the Company in reliance on this Authorization, by sending a written revocation to the Company’s Privacy Steward at PO Box 26580, Austin, Texas 78755-0580.

5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing this Authorization.

6. I understand that if the person or entity that receives my Protected Health Information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

7. I understand that a photocopy, facsimile copy, or other electronic copy of this Authorization is as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this Authorization. This Authorization will expire twenty-four (24) months from the date it is signed.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer’s behalf:

____________________________________________________________________________________________________________

____________________________________________________  ____________________________________________________

Consumer’s Name  Name of Consumer’s Personal Representative, if applicable

____________________________________________________  ____________________________________________________

Signature of Consumer  Date  Relationship of Personal Representative to the Consumer

____________________________________________________  ____________________________________________________

Signature of Company’s Agent  Date  Signature of Personal Representative  Date

A signed copy of this form will be provided to you.

HIPAA-MKT-CS

RETURN TO COMPANY

(1-3-14)
NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

AMERICAN RETIREMENT LIFE INSURANCE COMPANY®
PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

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 ARLIC. 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 the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, OR BROKER:

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 coverage is being purchased for the following reason (check one):

- additional benefits
- my plan has outpatient drug coverage and I am enrolling in Part D
- no change in benefits, but lower premiums
- disenrollment from a Medicare Advantage Plan – please explain reason for disenrollment _______________________
- fewer benefits and lower premiums
- other (please specify) ________________________________

NOTE:

1) If the Issuer of the Medicare Supplement policy being applied for does not or is otherwise prohibited from imposing pre-existing condition limitations, please skip to note 2 below. Health conditions which you may presently have (pre-existing conditions) 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 law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.

3) 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 premiums 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

Applicant’s Signature

Type or Print Name and Address of Agent/Broker

Date

ARLIC-MS-RN

RETURN TO COMPANY

06/13
NOTICE TO APPLICANT REGARDING REPLACEMENT OF
MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

AMERICAN RETIREMENT LIFE INSURANCE COMPANY®
PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

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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 ARLIC. 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 the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, OR BROKER:

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 coverage is being purchased for the following reason (check one):

- additional benefits
- my plan has outpatient drug coverage and I am enrolling in Part D
- no change in benefits, but lower premiums
- disenrollment from a Medicare Advantage Plan – please explain reason for disenrollment _______________________
- fewer benefits and lower premiums
- other (please specify) ________________________________

NOTE:
1) If the Issuer of the Medicare Supplement policy being applied for does not or is otherwise prohibited from imposing pre-existing condition limitations, please skip to note 2 below. Health conditions which you may presently have (pre-existing conditions) 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.

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3) 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 premiums 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  Applicant’s Signature

_________________________________________________  _______________________________________________
Type or Print Name and Address of Agent/Broker  Date

ARLIC-MS-RN  LEAVE WITH APPLICANT  06/13
Notice and Customer Information Form

To help the government fight the funding of terrorism and money laundering activities, Federal law requires us to obtain all relevant customer-related information necessary to run an effective anti-money laundering program.

**What this means to you:** When submitting an application/order ticket/request form, we ask that the producer obtain the client’s name, street address, date of birth, tax identification number, and other customer-related information that will allow us to identify the customer and fulfill our obligations under Federal law. Picture documentation, such as a driver’s license or other identifying documents, will be used to verify the information given at the time of the sale.

By acknowledging receipt of this Notice and Customer Information Form, the undersigned authorizes any law enforcement agency, public or private institution, information service bureau, or other entity contacted by the Company identified above to furnish information sufficient to confirm the personal information of the undersigned as required by Federal law. This information is confidential and will not be used for any other purpose. The undersigned hereby releases all persons, agents and agencies, and entities providing confirming information from any and all liability arising out of the request for or the release of confirming information.

The owner information section must be completed in its entirety. If identification documents are not available, the customer must sign the form and the information will be verified by the Company.

The following information must be obtained for each tax identification number or social security number disclosed on the application for insurance.

<table>
<thead>
<tr>
<th>FEIN/SSN</th>
<th>Owner Name</th>
<th>Verification of ID</th>
<th>State/Country</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ Driver’s License/State ID</td>
<td>Number</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Other</td>
<td>State/Country</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)</td>
<td>Number</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Occupation</td>
<td>Date Issued</td>
<td>Exp. Date</td>
</tr>
<tr>
<td>Employer</td>
<td></td>
<td>State/Country</td>
<td>Number</td>
</tr>
</tbody>
</table>

**Additional Owner**

<table>
<thead>
<tr>
<th>FEIN/SSN</th>
<th>Person’s Name</th>
<th>Verification of ID</th>
<th>State/Country</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Person’s Name</td>
<td>□ Driver’s License/State ID</td>
<td>Number</td>
</tr>
<tr>
<td></td>
<td>Person’s Name</td>
<td>□ Other</td>
<td>State/Country</td>
</tr>
<tr>
<td></td>
<td>Person’s Name</td>
<td>□ Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)</td>
<td>Number</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Occupation</td>
<td>Date Issued</td>
<td>Exp. Date</td>
</tr>
<tr>
<td>Employer</td>
<td></td>
<td>State/Country</td>
<td>Number</td>
</tr>
</tbody>
</table>

II. The source of funds for this transaction is ____________________________________________________________

III. The purpose of this transaction is ________________________________________________________________

**Agent:** I have examined and verified the customer’s ID as noted above is true and correct to the best of my knowledge and belief.

__________________________________________________  _________________________________________________

Agent’s Printed Name  Agent Number

__________________________________________________  _________________________________________________

Agent’s Signature  Date

--------------- COMPLETE THIS PORTION ONLY IF THE APPLICANT DOES NOT HAVE IDENTIFICATION DOCUMENTS ---------------

**Customer(s):** I acknowledge the foregoing notice and certify that the foregoing information is true and correct to the best of my knowledge and belief.

__________________________________________________  _________________________________________________

Owner’s Printed Name  Owner’s Signature  Date

__________________________________________________  _________________________________________________

Additional Owner’s Printed Name  Additional Owner’s Signature  Date
ACCELERATED BENEFIT TERMINAL ILLNESS RIDER DISCLOSURE STATEMENT

AN ACCELERATED BENEFIT THAT IS PAID ON ACCOUNT OF THIS RIDER WILL REDUCE THE DEATH BENEFITS OF THE POLICY. SUCH PAYMENT WILL ALSO REDUCE THE CASH VALUE OR OTHER VALUES OF THE POLICY, IF ANY. SOME PART OR ALL OF SUCH A PAYMENT MAY BE TAXABLE. AS WITH ALL TAX MATTERS, A TAX ADVISOR SHOULD BE CONSULTED.

What is an accelerated benefit? An accelerated benefit is the payment of a part of the proceeds of your life insurance policy before the death of an Insured. ("You" and “Your” refer to the Owner of the policy to which this rider is attached.)

Who can qualify for an accelerated benefit? An accelerated benefit may be paid with respect to the Insured or any additional Insured. The accelerated benefit will be paid only one time for each Insured.

When can I receive an accelerated benefit? Payment may be made to the Owner when an Insured has been diagnosed with a medical condition that results in a life expectancy of 12 months or less.

How much of the proceeds can be paid as an accelerated benefit? An accelerated benefit is paid from the Present Value of the Eligible Proceeds of your policy. The Eligible Proceeds are the death benefits of the policy (or combined policies) less any decreasing term riders and level term riders that will terminate within one year. Subject to the minimums and maximums described below, you may choose how much of the Eligible Proceeds are to be paid as an accelerated benefit.

In order to receive an accelerated benefit, you must have at least $10,000 in Eligible Proceeds. The Eligible Proceeds that are to be paid as an accelerated benefit must be at least $5,000. You may combine all policies that you have in force with us to satisfy these minimums.

You may not have more than 50% of your Eligible Proceeds paid as an accelerated benefit. You may not have more than $200,000 of Eligible Proceeds paid as an accelerated benefit. These maximums apply to the total of all policies you have in force with us.

When proceeds are to be paid as an accelerated benefit, is there a reduction for early payment? Yes, the Eligible Proceeds that are to be paid as an accelerated benefit are reduced to present value. The present value calculation takes into account the premiums we would have expected to receive in the future had the accelerated benefit not been elected, as well as an administrative fee. This means the amount you receive will always be less than the Eligible Proceeds you choose to be accelerated.

What is the administrative fee when an accelerated benefit is to be paid? We may charge an administrative fee of up to $100 when an accelerated benefit is to be paid. This fee will be included as part to the present value calculation. We will notify you if an administrative fee is charged.

How is the accelerated benefit paid? You may choose to have the accelerated benefit paid to you in a lump sum or in equal monthly installments. The Limited Life Expectancy Option provides for 12 months of installments.

What if the Insured dies before all payments are made? If the Insured dies before all payments are made, the present value of future payments will be paid to the beneficiary in a lump sum.

How will the payment of an accelerated benefit affect my policy? After the payment of an accelerated benefit, your policy will remain in force for a reduced Face Amount. The policy proceeds and all policy values will be reduced by the percentage of the Eligible Proceeds you elect to accelerate. Policy values that will be reduced include:

(a) death benefit face amount;
(b) future policy premiums (excluding the policy fee);
(c) cash values, if any;
(d) amounts available under the Reduced Paid-Up Nonforfeiture Option; and
(e) policy loan amounts outstanding.
Any policy fees associated with the policy will not be reduced.

Here is an example of how an accelerated benefit affects a policy:

<table>
<thead>
<tr>
<th>Death Benefit (Eligible Proceeds)</th>
<th>Premium plus any policy fees</th>
<th>Cash Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before accelerated payment</td>
<td>$100,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>After accelerated payment</td>
<td>$ 50,000</td>
<td>$  500</td>
</tr>
</tbody>
</table>

Do I have to pay an additional premium if the Rider is added to my policy? No, there is no additional premium charged if you add the rider to your policy.

When does the Rider terminate? The rider will terminate on the date an accelerated benefit is paid, the date you sent the company a written request to terminate the rider, or the date the policy terminates.

<table>
<thead>
<tr>
<th>Signature of Proposed Insured</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Additional Insured</td>
<td>Date</td>
</tr>
<tr>
<td>Signature of Owner</td>
<td>Date</td>
</tr>
<tr>
<td>Signature of Agent or Company Representative</td>
<td>Date</td>
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ACCELERATED BENEFIT TERMINAL ILLNESS RIDER DISCLOSURE STATEMENT

AN ACCELERATED BENEFIT THAT IS PAID ON ACCOUNT OF THIS RIDER WILL REDUCE THE DEATH BENEFITS OF THE POLICY. SUCH PAYMENT WILL ALSO REDUCE THE CASH VALUE OR OTHER VALUES OF THE POLICY, IF ANY. SOME PART OR ALL OF SUCH A PAYMENT MAY BE TAXABLE. AS WITH ALL TAX MATTERS, A TAX ADVISOR SHOULD BE CONSULTED.

What is an accelerated benefit? An accelerated benefit is the payment of a part of the proceeds of your life insurance policy before the death of an Insured. ("You" and "Your" refer to the Owner of the policy to which this rider is attached.)

Who can qualify for an accelerated benefit? An accelerated benefit may be paid with respect to the Insured or any additional Insured. The accelerated benefit will be paid only one time for each Insured.

When can I receive an accelerated benefit? Payment may be made to the Owner when an Insured has been diagnosed with a medical condition that results in a life expectancy of 12 months or less.

How much of the proceeds can be paid as an accelerated benefit? An accelerated benefit is paid from the Present Value of the Eligible Proceeds of your policy. The Eligible Proceeds are the death benefits of the policy (or combined policies) less any decreasing term riders and level term riders that will terminate within one year. Subject to the minimums and maximums described below, you may choose how much of the Eligible Proceeds are to be paid as an accelerated benefit.

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When proceeds are to be paid as an accelerated benefit, is there a reduction for early payment? Yes, the Eligible Proceeds that are to be paid as an accelerated benefit are reduced to present value. The present value calculation takes into account the premiums we would have expected to receive in the future had the accelerated benefit not been elected, as well as an administrative fee. This means the amount you receive will always be less than the Eligible Proceeds you choose to be accelerated.

What is the administrative fee when an accelerated benefit is to be paid? We may charge an administrative fee of up to $100 when an accelerated benefit is to be paid. This fee will be included as part to the present value calculation. We will notify you if an administrative fee is charged.

How is the accelerated benefit paid? You may choose to have the accelerated benefit paid to you in a lump sum or in equal monthly installments. The Limited Life Expectancy Option provides for 12 months of installments.

What if the Insured dies before all payments are made? If the Insured dies before all payments are made, the present value of future payments will be paid to the beneficiary in a lump sum.

How will the payment of an accelerated benefit affect my policy? After the payment of an accelerated benefit, your policy will remain in force for a reduced Face Amount. The policy proceeds and all policy values will be reduced by the percentage of the Eligible Proceeds you elect to accelerate. Policy values that will be reduced include:

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Do I have to pay an additional premium if the Rider is added to my policy? No, there is no additional premium charged if you add the rider to your policy.

When does the Rider terminate? The rider will terminate on the date an accelerated benefit is paid, the date you sent the company a written request to terminate the rider, or the date the policy terminates.
DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE. THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured ___________________________  Age __________  Sex __________

Name of Agent Preparing Disclosure ____________________________________________________________

Home or Agency Address of Agent _______________________________________________________________

Telephone Number of Agent _____________________________________________________________________

Insurer: American Retirement Life Insurance Company

Direct all correspondence to: American Retirement Life Insurance Company, PO Box 26580, Austin, TX 78755-9004

<table>
<thead>
<tr>
<th>Policy</th>
<th>DESCRPTIVE TITLE OF COVERAGE</th>
<th>FACE AMOUNT OF COVERAGE [If not applicable, DESCRPITIVE TITLE OF COVERAGE]</th>
<th>FACE AMOUNT OF COVERAGE [If not known, PREMIUM FOR MODE QUOTED]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final Expense Whole Life Policy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Benefit(s) (built into Policy)</td>
<td>Accelerated Benefit Terminal Illness Rider</td>
<td>This Rider will provide either a lump sum benefit amount or periodic payments upon the first diagnosis of a qualifying event. There is no charge for this Rider prior to the time a benefit is paid.</td>
<td>The cost is included in the premium for the policy.</td>
</tr>
</tbody>
</table>

The Face Amount of coverage of the Whole Life Policy changes as follows: The Face Amount of the policy remains level for the life of the insured as long as the policy remains in force for the Whole Life Policy.

The planned period premium is _________________  The frequency to be paid is __________________________
Guaranteed Cash Value: If you continuously pay your premiums on this policy as they become due, you will have the following guaranteed cash surrender value for each $1,000 of Face Amount. You may borrow against this cash value at an annual 8.0% loan interest rate.

<table>
<thead>
<tr>
<th>Number of years Policy has been in force</th>
<th>Cash Value per $1,000 (of total Face Amount)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Age 65</td>
<td></td>
</tr>
</tbody>
</table>

A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

The prospective insured ☐ has ☐ has not requested an early delivery of the index (check appropriate box). Upon request, either the Company or Agent will furnish you with additional information about the insurance described.

APPLICANT CERTIFICATION

The undersigned does hereby certify that the written disclosure statement was given no later than the time that the application was signed by the Applicant.

_________________________________________________________________  _________________________
Signature of Applicant Date

_________________________________________________________________
Print or Type Name
# DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE. THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured: ____________________________  Age: _______  Sex: _______

Name of Agent Preparing Disclosure: ____________________________________________

Home or Agency Address of Agent: _______________________________________________

Telephone Number of Agent: _____________________________________________________

**Insurer:** American Retirement Life Insurance Company

**Direct all correspondence to:** American Retirement Life Insurance Company, PO Box 26580, Austin, TX 78755-9004

<table>
<thead>
<tr>
<th>Policy</th>
<th>Descriptive Title of Coverage</th>
<th>Face Amount of Coverage [If not applicable, Descriptive Title of Coverage]</th>
<th>Face Amount of Coverage [If not known, Premium for Mode Quoted]</th>
</tr>
</thead>
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<tr>
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The planned period premium is __________________  The frequency to be paid is __________________________
**Guaranteed Cash Value:** If you continuously pay your premiums on this policy as they become due, you will have the following guaranteed cash surrender value for each $1,000 of Face Amount. You may borrow against this cash value at an annual 8.0% loan interest rate.

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A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

The prospective insured ☐ **has** ☐ **has not** requested an early delivery of the index (check appropriate box). Upon request, either the Company or Agent will furnish you with additional information about the insurance described.

**APPLICANT CERTIFICATION**

The undersigned does hereby certify that the written disclosure statement was given no later than the time that the application was signed by the Applicant.

________________________________________  _________________________  
Signature of Applicant                          Date

________________________________________
Print or Type Name
IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

You have indicated that you intend to replace your existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under the existing policy, the period of time during which the issuing company could contest the policy because of (a) a material misrepresentation or omission concerning the medical information requested in your application or (b) deny coverage for death caused by suicide may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that, in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy, thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it, and have found it acceptable to you.

________________________________________________________________  _________________________
Applicant’s Signature Date

________________________________________________________________  _________________________
Agent’s Signature Date

_________________________________________________________________________________________________
Existing Insurer
IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

You have indicated that you intend to replace your existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under the existing policy, the period of time during which the issuing company could contest the policy because of (a) a material misrepresentation or omission concerning the medical information requested in your application or (b) deny coverage for death caused by suicide may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy’s cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that, in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy, thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it, and have found it acceptable to you.

_________________________________________________________________  _________________________
Applicant’s Signature  Date

_________________________________________________________________  _________________________
Agent’s Signature  Date

_________________________________________________________________________________________________
Existing Insurer