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

Application Booklet for TEXAS

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
- 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>
<thead>
<tr>
<th>First</th>
<th>Name of Applicant</th>
<th>MI</th>
<th>Last</th>
<th>Age</th>
<th>Date of Birth MM</th>
<th>DD</th>
<th>YYYY</th>
<th>State of Birth</th>
</tr>
</thead>
</table>

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 ___________________________ Height Ft. _____ In. _______ Weight Lbs. ______

Have you used tobacco within the last 12 months? ☐ Yes ☐ No  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) ☐ OE ☐ GI

Check Plan selected: ☐ Plan A ☐ Plan F ☐ Plan G ☐ Plan N  Modal Premium $__________

### SECTION IV: WHOLE LIFE COVERAGE APPLIED FOR

If you are in Open Enrollment or eligible for Guaranteed Issue of 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* $__________

*Modal Premium includes a $36 annual policy fee

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 enrollment fee

Medicare Supplement Policy Modal Premium $__________
Whole Life Insurance Policy Modal Premium $__________
One-time Enrollment Fee* $______20 $__________

Total Premium with Application $__________
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) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your “START” and “END” dates below. If you are still covered under this plan, leave “END” date blank:
   START ___________________ END ___________________
   a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? .................................................................
   b) Was this your first time in this type of Medicare plan? ................................................
   c) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ................

4) Do you have another Medicare Supplement policy in force? ...........................................
   a) If so, with what company and what type plan do you have? ........................................
   b) 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 VIII: EXISTING COVERAGE & REPLACEMENT (IF APPLYING FOR WHOLE LIFE INSURANCE, PLEASE COMPLETE THIS SECTION)

1) Do you, the Applicant, have existing individual life insurance policies or individual annuity contracts with this or any other company? ................................................................. YES ☐ NO ☐

If “YES”, (a) the Applicant and Agent must complete the required “Important Notice: Replacement of Life Insurance or Annuities” form; (b) the Agent must complete the Section “Agent Provided Sales Material Statement” below and sign; and (c) provide the following information (use additional sheet, if needed):

<table>
<thead>
<tr>
<th>Insurance Company Name and Address</th>
<th>Contract or Policy Number</th>
<th>Is Coverage being Replaced?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>YES ☐ NO ☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES ☐ NO ☐</td>
</tr>
</tbody>
</table>

Applicant’s Signature/Printed Name ___________________________ Date ______________

Agent’s Signature/Printed Name ___________________________ Date ______________

2) AGENT PROVIDED SALES MATERIAL STATEMENT (MUST BE COMPLETED BY THE AGENT ONLY IF THE APPLICANT IS REPLACING EXISTING LIFE INSURANCE OR ANNUITY): I hereby certify that in connection with my presentation to the Applicant herein, I only used sales material that was previously approved by American Retirement Life Insurance Company and that I left with or provided to the Applicant a copy of the sales material used in my presentation to the Applicant.

Agent’s Signature/Printed Name ___________________________ Date ______________

SECTION IX: MEDICAL QUESTIONS

FOR MEDICARE SUPPLEMENT: If you are in Open Enrollment or eligible for Guaranteed Issue (based on your answers in Sections VI & VII), DO NOT ANSWER the questions in this section.

IF APPLYING FOR WHOLE LIFE INSURANCE, PLEASE ANSWER ALL 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? ................................................................. YES ☐ NO ☐

2) Do you require or receive any assistance with bathing, transferring, toileting, eating, or dressing? ................................................................. YES ☐ NO ☐

3) Are you currently bedridden or do you use the assistance of a wheelchair, walker, or motorized mobility aid? ................................................................. YES ☐ NO ☐

4) Within the past two (2) years, have you:
   a) been diagnosed 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? ................................................................. YES ☐ NO ☐
   b) been diagnosed with or treated (other than with maintenance medication) 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? ................................................................. YES ☐ NO ☐
   c) had a stroke or Transient Ischemic Attack (TIA)? ................................................................. YES ☐ NO ☐
   d) had any condition requiring dialysis, pancreatitis, or any condition requiring an organ transplant? ................................................................. YES ☐ NO ☐

5) Do you have now or in the last two (2) years have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions:
   a) hepatitis (other than hepatitis A), cirrhosis of the liver, or other liver disease? ................................................................. YES ☐ NO ☐
   b) major depression, bipolar disorder, schizophrenia, or a paranoid disorder? ................................................................. YES ☐ NO ☐
   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? ................................................................. YES ☐ NO ☐
   d) chronic kidney disease, Addison’s Disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant? ................................................................. YES ☐ NO ☐
   e) internal cancer, leukemia, malignant melanoma, Hodgkin’s Disease, or lymphoma? ................................................................. YES ☐ NO ☐

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f) alcohol or drug abuse? .........................................................

YES NO

g) paralysis, hemophilia, osteoporosis with fractures, or unrepaird aneurysm? ..................................................

h) Paget's Disease, rheumatoid or disabling arthritis, systemic lupus, or other connective tissue disorder? ... 

6) Do you have now or at any time have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions:
   a) Parkinson's Disease, myasthenia gravis, multiple or amyotrophic lateral sclerosis (Lou Gehrig's Disease), muscular dystrophy, cerebral palsy, dementia, senility, Alzheimer's Disease, or organic brain disorder? .... 

  b) emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic Obstructive Lung Disease (COLD), or any chronic lung or respiratory disorder requiring the use of oxygen? ..........................................

  c) amputation caused by disease or organ transplant other than corneas? ...........................................................

7) Have you ever been diagnosed with or received medical advice or treatment from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection? ..........

8) Do you have now or in the last three (3) years have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for anemia requiring repeated blood transfusions, or any other blood disorder? ...........................................................................................................................

9) Has surgery been advised but not performed or is any surgery anticipated, including but not limited to joint replacement or cataract surgery? ..........................................................

10) Have medical tests (other than mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only), treatment, or therapy been advised but not performed? ..........................................................

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.

YES NO

11) In the past two (2) years, have you had PSA levels greater than 6.0 or been diagnosed 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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12) 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

13) Please list any prescription medications taken or prescribed in the past two (2) years.

   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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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 more than one type of coverage in addition to your Medicare benefits.
- 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 ☐ I do not grant my authorization to receive information or presentation of materials describing other insurance products.

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.

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

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
SECTION XI: AGENT(S) CERTIFICATION

Agent(s) shall list any health insurance policies they have sold to the Applicant.

1) List any other health policies or coverage you sold which are still in force (if this does not apply, state “NONE”):

________________________________________________________________________________________

________________________________________________________________________________________

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

________________________________________________________________________________________

________________________________________________________________________________________

3) Have you submitted any applications or have knowledge of any applications submitted for this Applicant that have been declined? ......................................................................................................................................

If “YES”, provide details below.

________________________________________________________________________________________

________________________________________________________________________________________

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

________________________________________________________________________________________

________________________________________________________________________________________

5) 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 date

☐ Mail date

☐ Email date

☐ Fax date

☐ Other (explain) date

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

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

8) 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 ______________________________
MEDICARE SUPPLEMENT SUPPLEMENTARY APPLICATION

Definitions of Eligible Person for Guaranteed Issue and Creditable Coverage

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 which 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 all 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 such provider if such individual were enrolled in a Medicare Advantage plan:
   A) The certification of the organization or plan has been terminated;
   B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
   C) 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 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 (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;
   D) The individual demonstrates, in accordance with guidelines established by the Secretary, that:
      i) the organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D, in relation to the individual including the failure to provide an individual on a timely basis medically-necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or
      ii) the organization or agent or other entity acting on the organization's behalf materially misrepresented the plan's provisions in marketing the plan to the individual;
   E) The individual meets such other exceptional conditions as the Secretary may provide.

3) The individual is enrolled with an entity listed in subparagraphs A - D of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph 2 of this subsection:
   A) an eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost);
   B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
   C) an organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
   D) an organization under a Medicare Select policy; and

4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
   A) of the insolvency of the issuer or bankruptcy of the non-issuer organization or of other involuntary termination of coverage or enrollment under the policy;
   B) the issuer of the policy substantially violated a material provision of the policy; or
   C) the issuer or an agent 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 terminates 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 1876 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 a Medicare Select policy and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or

6) The individual, upon first becoming enrolled in Medicare part B for benefits at age 65 or older, 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 outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.

8) The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

If any of the definitions apply to you, please complete an Application for Medicare Supplement Insurance and submit evidence of the date of termination or disenrollment. Application must be made for coverage no later than 63 days of termination or disenrollment.

The following is a definition of Creditable Coverage:
Creditable Coverage means (a) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); (b) a group health benefit plan provided by a health insurance carrier or an HMO; (c) an individual health insurance policy or evidence of coverage; (d) Part A or Part B of Title XVIII of the Social Security Act; (e) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (f) Chapter 55 of Title 10 (CHAMPUS); (g) a medical care program of the Indian Health Service or of a tribal organization; (h) a state health benefits risk pool; (i) a health plan offered under Chapter 89 of Title 5 (Federal Employees Health Benefits Program); (j) a public health plan (as defined in federal regulation); (k) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)); or (l) short-term, limited duration insurance.

I acknowledge receipt of this Supplementary Application.

____________________________________________________   ______________________________
Signature of Applicant    Date
### Pre-Authorization Agreement for Electronic Funds Transfer

**American Retirement Life Insurance Company**

**Proposed Insured’s Name**

<table>
<thead>
<tr>
<th>Proposed Insured’s Name</th>
<th>Policy Number (if available)</th>
</tr>
</thead>
</table>

**Financial Institution Name and Telephone Number**

<table>
<thead>
<tr>
<th>Financial Institution Name</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>

**Financial Institution Address**

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
</table>

**9-digit Routing Number**

<table>
<thead>
<tr>
<th>9-digit Routing Number</th>
<th>Account Number</th>
<th>Requested Withdrawal Date (1st - 28th)</th>
</tr>
</thead>
</table>

**Withdraw Payment**

- [ ] Monthly
- [ ] Quarterly
- [ ] Semi-annually
- [ ] Annually

**Type of Account**

- [ ] Personal Checking Account
- [ ] Personal Savings Account
- [ ] Corporate/Business Checking

**Name of Employer Group**

<table>
<thead>
<tr>
<th>Name of Employer Group</th>
</tr>
</thead>
</table>

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

- [ ] New authorization
- [ ] Change in checking/savings account
- [ ] Change in financial institution
- [ ] Change in existing coverage

**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 Company 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)**

<table>
<thead>
<tr>
<th>Name of Payor (if other than Insured)</th>
<th>Payor’s Address</th>
</tr>
</thead>
</table>

**Print name of Depositor (as it appears on account)**

<table>
<thead>
<tr>
<th>Print name of Depositor (as it appears on account)</th>
<th>Signature of Depositor</th>
<th>Date</th>
</tr>
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</table>

**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.
AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT’S PROTECTED HEALTH INFORMATION

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.
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. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new 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
- no change in benefits, but lower premiums
- fewer benefits and lower premiums
- my plan has outpatient drug coverage and I am enrolling in Part D
- disenrollment from a Medicare Advantage Plan – please explain reason for disenrollment
- 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
NOTICE TO APPLICANT REGARDING REPLACEMENT OF
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- □ 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:
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_________________________  ___________________________
Agent’s Signature  Applicant’s Signature

Type or Print Name and Address of Agent/Broker  Date

ARLIC-MS-RN-TX  LEAVE WITH APPLICANT  06/13
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.

### I. Owner

<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>□ Passport</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Other</td>
<td></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></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Occupation</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td></td>
<td></td>
<td></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></td>
<td>□ Driver’s License/State ID</td>
<td>□ Passport</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Other</td>
<td></td>
</tr>
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</thead>
<tbody>
<tr>
<td>Employer</td>
<td></td>
<td></td>
<td></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 TERMINAL ILLNESS BENEFIT 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.

THE ACCELERATION-OF-LIFE-INSURANCE BENEFITS OFFERED UNDER THIS RIDER MAY OR MAY NOT QUALIFY FOR FAVORABLE TAX TREATMENT UNDER THE INTERNAL REVENUE CODE OF 1986. WHETHER SUCH BENEFITS QUALIFY DEPENDS ON FACTORS SUCH AS YOUR LIFE EXPECTANCY AT THE TIME BENEFITS ARE ACCELERATED OR WHETHER YOU USE THE BENEFITS TO PAY FOR NECESSARY LONG-TERM CARE EXPENSES, SUCH AS NURSING HOME CARE. IF THE ACCELERATION-OF-LIFE-INSURANCE BENEFITS QUALIFY FOR FAVORABLE TAX TREATMENT, THE BENEFITS WILL BE EXCLUDABLE FROM YOUR INCOME AND NOT SUBJECT TO FEDERAL TAXATION. TAX LAWS RELATING TO ACCELERATION-OF-LIFE-INSURANCE BENEFITS ARE COMPLEX, YOU ARE ADVISED TO CONSULT WITH A QUALIFIED TAX ADVISOR ABOUT CIRCUMSTANCES UNDER WHICH YOU COULD RECEIVE ACCELERATION-OF-LIFE-INSURANCE BENEFITS EXCLUDABLE FROM INCOME UNDER FEDERAL LAW.

Receipt of acceleration-of-life-insurance benefits may affect You, Your spouse, or Your family’s eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect You, Your spouse, and Your family’s eligibility for public assistance.

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 24 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 of 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. Please refer to the Eligibility provisions of the Rider for more details about how payments may be made.

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.

Will I have to continue making premium payments on my policy after payment of an accelerated death benefit? Yes. However, you will only have to make premium payments on the portion of your policy that remains in force. For example, if 50% of your Eligible Proceeds were paid as an accelerated benefit, you would continue to pay premiums on the 50% of the Face Amount that remains in force.

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>$100,000</td>
<td>$1,000</td>
<td>$26,000</td>
</tr>
<tr>
<td>$50,000</td>
<td>$500</td>
<td>$13,000</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.

---

Signature of Proposed Insured  
Date

Signature of Additional Insured  
Date

Signature of Owner  
Date

Signature of Agent or Company Representative  
Date
American Retirement Life Insurance Company®
(Hereinafter called: the Company, We, Our, or Us)
Home Office: 1300 East Ninth Street, Cleveland, OH 44114
Administrative Office: PO Box 559015, Austin, TX 78755-9015
Customer Service: 866-459-4272

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In order to receive an accelerated benefit, you must have a 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.

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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 of 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. Please refer to the Eligibility provisions of the Rider for more details about how payments may be made.

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.

Will I have to continue making premium payments on my policy after payment of an accelerated death benefit? Yes. However, you will only have to make premium payments on the portion of your policy that remains in force. For example, if 50% of your Eligible Proceeds were paid as an accelerated benefit, you would continue to pay premiums on the 50% of the Face Amount that remains in force.

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</tr>
</thead>
<tbody>
<tr>
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<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>

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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.
IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES
This document must be signed by the Applicant and the Producer (if there is one) and a copy left with the Applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy or contract and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1) Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ............................................... YES □ NO □

2) Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ............................................................................................................................................. YES □ NO □

If you answered “YES” to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

<table>
<thead>
<tr>
<th>INSURER NAME</th>
<th>CONTRACT/POLICY NUMBER</th>
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Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because __________________________________________________________

I certify that the responses herein are accurate, to the best of my knowledge:

__________________________________________________________  ___________________________
Applicant’s Signature and Printed Name  Date

__________________________________________________________  ___________________________
Agent’s Signature and Printed Name  Date

I do not want this notice read aloud to me. ________ (Applicant: initial only if you do not want the notice read aloud)
A replacement may not be in your best interest or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
- Are they affordable?
- Could they change?
- You're older – are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? on the old policy?

POLICY VALUES:
- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:
- If your health has changed since you bought your old policy, the new one could cost you more or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST-SENSITIVE LIFE PRODUCT:
- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor.)
- Is there a benefit from favorable “grandfathered” treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?
IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES
This document must be signed by the Applicant and the Producer (if there is one) and a copy left with the Applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of, or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy or contract and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1) Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?  ...............................................  YES ☐ NO ☐

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If you answered “YES” to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

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The existing policy or contract is being replaced because

I certify that the responses herein are accurate, to the best of my knowledge:

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