

Underwritten By:  
 TRANSAMERICA Financial Life Insurance Company  
 440 Mamaroneck Avenue, Harrison, New York 10528

### To Apply

1. Check the Plan you want. Complete and sign the form below. Make sure you answer all the questions and read all the statements.
2. Enclose your check or money order for your first premium payment for the Plan you've chosen. Make your check payable to **TRANSAMERICA Financial Life Insurance Company**

NAME \_\_\_\_\_  
 ADDRESS 6 E 43<sup>rd</sup> Street  
 11th floor  
 New York, NY 10017  
 491870101

Persons to be covered: <input type="checkbox"/> Applicant <input type="checkbox"/> Applicant and Spouse	
Your Date of Birth: _____ (Month/Day/Year)	Spouse's Name: _____
Telephone #: _____	Spouse's Date of Birth: _____ (Month/Day/Year)
Your Social Security #: _____ - _____ - _____	Spouse's Social Security #: _____ - _____ - _____
Medicare ID #: _____ <small>(Found on your Medicare I.D. card)</small>	Medicare ID #: _____ <small>(Found on your Medicare I.D. card)</small>

Plan applying for:     Plan A     Plan B     Plan C     Plan D     Plan E  
                                   Plan F     Plan G     Plan H     Plan I     Plan J

#### Medicare Supplement Information to Consider

- You do not need more than one Medicare Supplement policy or certificate.
- If you purchase this policy or certificate, 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 or certificate.
- The benefits and premiums under your Medicare Supplement policy or certificate 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 policy or certificate will be reinstated within 90 days of losing Medicaid eligibility.
- 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).

**The following questions must be answered to the best of your knowledge and belief:**

	MEMBER	SPOUSE
(1) Do you have another Medicare Supplement insurance policy or certificate in force? (a) If so, with which company? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(2) Do you have any other accident and health insurance policies or certificates (including a health maintenance organization contract) that provide benefits similar to this Medicare Supplement policy or certificate? (a) If so, with which company? _____ (b) What kind of policy? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(3) Are you enrolled in a Medicare+Choice plan that provides benefits which duplicates those provided by this Medicare Supplement that provide benefits? (a) If so, with which company? _____ (b) What type of plan? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(4) If the answer to question (1), (2) or (3) is yes, do you intend to replace any of these policies or certificates with this policy or certificate? (a) If so, identify the policies or certificates to be replaces. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(5) Within the last 63 days, were you covered under another accident and health insurance policy, Medicare Supplement policy, HMO contract or employer-provided health benefit arrangement? (a) If so, how long were you covered under that plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No  ___ Years ___ Months	<input type="checkbox"/> Yes <input type="checkbox"/> No  ___ Years ___ Months
(6) Are you covered for medical assistance through the state Medicaid program: (a) As a Specified Low Income Medicare Beneficiary (SLMB)? (b) As a Qualified Medicare Beneficiary (QMB)? (c) For other Medicaid medical benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
(7) If the answer to question (6)(a), (b) or (c) is yes, will the State Medicaid program pay the premiums for the policy for certificate being applied for?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

I hereby apply for coverage in the Medicare Supplement Plan provided TRANSAMERICA Financial Life Insurance Company. I understand this insurance will be effective on the first of the month following acceptance of my application and first premium. I understand that this coverage will not pay benefits for conditions for which I or my spouse (if to be covered) have received medical treatment or advice within the last 6 months prior to the effective date until I or my spouse have been insured for 6 consecutive months. If this policy or certificate replaces Medicare Supplement Insurance, accident and health insurance, HMO coverage or employer-provided health benefits which was continuously in force up to 63 days prior to the effective date of this policy or certificate, then TRANSAMERICA Financial Life Insurance Company will credit the amount time you were covered under the prior plan towards the pre-existing conditions limitations waiting period in your new policy or certificate. I am aware that this coverage is coordinated with Medicare Parts A and B and attest that I/we have such Medicare coverage.

Applicant's Signature X \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature X \_\_\_\_\_ Date \_\_\_\_\_  
 (if to be insured)

**NOTICE: The sale of a Medicare Supplement insurance policy or certificate is prohibited where an individual has a Medicare Supplement policy in force and does not desire to replace the existing policy or where the Medicare Supplement policy would duplicate benefits to which the individual is entitled under a Medicare+Choice plan.**

**Any person who knowingly wand 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 shall also be subject to a civil penalty not to exceed Five Thousand Dollars and the stated value of the claim for each such violation.**