



**Underwritten by
Tier One Insurance Company**

Home Office: 1932 Wynnton Road, Columbus, GA 31999

Administrative Office: 1021 Reams Fleming Blvd., Franklin, TN 37064

Telephone Number: 1-833-504-0336 Website: www.Aflac.com

Application

Medicare Supplement Insurance

Illinois

Application for Medicare Supplement Insurance

- If only one applicant, just complete Applicant A information.
- Complete all required sections of the application. Any incomplete or missing information could result in delay or closure of your application.

Section 1a. Applicant A Information

Applicant A name (as appears on Medicare card*)

Phone

Residential address

Apt/suite number

City

State

Zip

Mailing address (if different than residential address)

Apt/suite number

City

State

Zip

E-mail

Social Security Number

Birth date (mm/dd/yyyy)

Age

☐ Male
☐ Female

Height (feet and inches)

Weight (pounds)

Are you a legal resident of the United States?

☐ Yes

☐ No

Have you used any form of tobacco in the past 12 months? (Including vaping and e-cigarettes)

☐ Yes

☐ No

Medicare card number*

Effective date: Medicare Part A

Medicare Part B

**Please provide complete Medicare number and a copy of card if possible.
If applicant has not received a Medicare card yet, leave blank.*

Section 1b. Applicant B Information

Applicant B name (as appears on Medicare card*)

Phone

Residential address

Apt/suite number

City

State

Zip

Mailing address (if different than residential address)

Apt/suite number

City

State

Zip

E-mail

Social Security Number

Birth date (mm/dd/yyyy)

Age

☐ Male
☐ Female

Height (feet and inches)

Weight (pounds)

Are you a legal resident of the United States?

☐ Yes

☐ No

Have you used any form of tobacco in the past 12 months? (Including vaping and e-cigarettes)

☐ Yes

☐ No

Medicare card number*

Effective date: Medicare Part A

Medicare Part B

Section 2a. Household Premium Discount Information

Household Premium Discount Eligibility Information

You may qualify for a Medicare Supplement household discount with Tier One Insurance Company if (1) you reside with your spouse (including civil union/domestic partner), or (2) you have been living with a family member who is age 50 or older for the last twelve months.

(For the purpose of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in your state of residence.)

If you are eligible based on the above requirements, the discount will be 10 percent lower than the individual rates and will apply as long as these requirements are met.

Applicant(s) meet(s) these eligibility requirements ☐ Yes ☐ No

Upon verification of eligibility and approval of your application, you will qualify for the discount.

If you answered Yes to the question above, please fill out the following information about the household resident, unless both applicants are applying for coverage on this application:

Name	Policy number (if applicable)	Relationship to Applicant
------	-------------------------------	---------------------------

Mail policy(ies) to: ☐ Applicant(s) ☐ Agent

Section 2b. Plan and Premium Information – Applicant A

Payment Modes

You have a choice among several payment options or modes for paying your premium: annual, semi-annual, quarterly and monthly electronic funds transfer (EFT). Each payment mode, other than annual and monthly electronic funds transfer, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates. The annual and monthly electronic funds transfer modes have the same and lowest total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You may change your payment mode, among the modes available, during the life of your policy.

Applicant A Plan selected*

Requested Medicare Supplement effective date (mm/dd/yyyy)

☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan N

*Plan F available to those first eligible before 01/01/2020

Modal premium	Modal premium with discount	Policy fee**	Total initial premium collected/draft
\$	\$	\$ 20.00	\$

Initial Premium

☐ Draft initial premium upon policy approval

☐ Draft initial premium on the policy effective date

Subsequent draft date***

Payment mode

☐ Annually ☐ Quarterly ☐ Semi-annually ☐ Monthly EFT

Initial Premium

☐ Check ☐ EFT ☐ List Bill Billing file identifier:

If applying for household discount, provide the discounted and non-discounted premium amounts.

Plans A, G and N are available to all applicants. Plan F is available **ONLY to those first eligible for Medicare before 1/1/2020.*

***This one-time fee will be refunded, along with your premium, if the policy is not issued or you return it during your 30-day free look.*

**** Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 15 days greater than the policy's paid to date will draft a month in advance.*

Section 2b. Plan and Premium Information – Applicant B

Applicant B Plan selected

Requested Medicare Supplement effective date (mm/dd/yyyy)

☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan N

*Plan F available to those first eligible before 01/01/2020

Modal premium	Modal premium with discount	Policy fee**	Total initial premium collected/draft
\$	\$	\$ 20.00	\$

Initial Premium

☐ Draft initial premium upon policy approval

☐ Draft initial premium on the policy effective date

Subsequent draft date***

Payment mode

☐ Annually ☐ Quarterly ☐ Semi-annually ☐ Monthly EFT

Initial Premium

☐ Check ☐ EFT ☐ List Bill Billing file identifier:

Section 3. Eligibility Questions

To the best of your knowledge:

Applicant:

1. Did you turn age 65 in the last 6 months?

A	B
<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

i. Did you enroll in Medicare Part B in the last 6 months?

ii. If yes, what is the effective date? (mm/dd/yyyy)

A Applicant A effective date

B Applicant B effective date

Section 3. Eligibility Questions *continued*

NOTE: If you are participating in a "Spend-Down Program" and have not met your "share of cost," please **answer no** to question 2.

		Applicant:	
		A	B
2. Are you covered for medical assistance through the state Medicaid program?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. If yes, will Medicaid pay your premiums for this Medicare Supplement policy?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been notified that your coverage under the state Medicaid program is terminating or has already terminated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," Did you still have coverage under the state Medicaid program on May 11, 2023 (the last day of the COVID-19 Public Health Emergency)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If both of the previous two answers were "Yes", fill in the following dates:			
<ul style="list-style-type: none"> The effective date of Medicaid coverage termination 			
____/____/____ MONTH DAY YEAR			
<ul style="list-style-type: none"> The date the notice of Medicaid termination was sent to you 			
____/____/____ MONTH DAY YEAR			
If at least one of the two dates was within the past 63 days, submit evidence of the date of termination of benefits or the notice of termination under the state Medicaid program. If you did not know that your Medicaid benefits had been terminated until you received a denial of a claim for benefits that specified termination as the reason, you may submit the denial letter.			
4. 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.			
A	Start date	End date	
B	Start date	End date	
i. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii. Was this your first time in this type of Medicare plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
iii. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you have another Medicare Supplement policy in force?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. If yes, for Applicant A, with what company, and what plan do you have?			
A	Company	Plan	
If yes, for Applicant B, with what company, and what plan do you have?			
B	Company	Plan	
ii. If so, do you intend to replace your current Medicare Supplement policy with this policy?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
iii. Are you replacing another Medicare Supplement policy from Tier One Insurance Company?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list the policy number:			
A	Applicant A		
B	Applicant B		

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.

6. Have you had coverage under any other health insurance within the past 63 days?

(For example, an employer, union, or individual plan)

☐ Yes ☐ No

☐ Yes ☐ No

i. If yes, with what company and what kind of policy do you have?

A

Company

Policy

B

Company

Policy

ii. What are your start and end dates of coverage under the other policy? (If you are still covered under the other policy, leave "End date" blank.)

A

Start date

End date

B

Start date

End date

----- **For agent use only** -----

Check if application is for:

Applicant A

☐ Open Enrollment

☐ Guaranteed Issue

☐ Underwritten

Applicant B

☐ Open Enrollment

☐ Guaranteed Issue

☐ Underwritten

Section 4: Health Questions

*Answer these questions **only** if you're applying for underwritten coverage.*

*Do not answer these questions for an **Open Enrollment** or **Guaranteed Issue** application.*

If any health questions are answered "yes" in section 4, the applicant(s) will not qualify for this insurance with us.

	Applicant:	
	A	B
1. Are you dependent on a wheelchair or any motorized mobility device?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do any of the following apply to you? Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. congestive heart failure, unoperated aneurysm, defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. leukemia, lymphoma, multiple myeloma, cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever tested positive for Human Immunodeficiency Virus (HIV) infection or been diagnosed by a Medical professional, acting within the scope of their license, as having ARC or AIDS caused by the HIV Infection or other sickness or conditions derived from such infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been medically diagnosed or treated by a member of the medical profession for diabetes?		
A. that requires use of insulin	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. with history of heart attack or stroke (at any time)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. alcoholism, drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. internal cancer, melanoma, Hodgkin's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. hepatitis, disorder of the pancreas	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4: Health Questions *continued*

	Applicant:	
	A	B
7. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. myasthenia gravis, systemic lupus or connective tissue disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. any lung or respiratory disorder and currently use tobacco products	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or surgery that has not been performed or do you have pending test results?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving injections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Within the past 12 months, do any of the following apply to you?		
A. had a pacemaker implanted	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. had a seizure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Was your last blood pressure reading higher than 175 systolic or higher than 100 diastolic?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<div style="border: 1px solid black; padding: 2px; display: inline-block;"> <i>Systolic is the upper number and diastolic is the bottom number of the blood pressure reading.</i> </div>		

Section 5: Health History – Applicant A

*If this is an **Open Enrollment** or **Guaranteed Issue** application, do not answer questions in this section.*

Applicant A

Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

List the name of any medications you are taking and the reason why, if known:

Section 5: Health History – Applicant B

Applicant B

Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

List the name of any medications you are taking and the reason why, if known:

Use an additional sheet of paper if needed for explanation.

*If this is an **Open Enrollment** or **Guaranteed Issue** application, do not answer questions in this section.*

Section 6: Physician Information – Applicant A

Applicant A primary physician

Phone

Physician's office name

City

State

Specialist seen in the past 24 months

Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months

Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months

Specialty

Reason for seeing (diagnosis)

Have you seen any additional physicians other than those listed above in the past 24 months?

☐ Yes ☐ No

Section 6: Physician Information – Applicant B

Applicant B primary physician

Phone

Physician's office name

City

State

Specialist seen in the past 24 months

Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months

Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months

Specialty

Reason for seeing (diagnosis)

Have you seen any additional physicians other than those listed above in the past 24 months?

☐ Yes ☐ No

Section 7. Important Statements

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Section 8. Producer Compensation

When you purchase insurance from us, we pay compensation to the licensed agent. Intermediaries through whom the licensed agent works may also receive compensation.

The agent or intermediary represents us by simply taking your insurance application, collecting your initial premiums and delivering your policy.

Agent compensation may vary depending on the type of insurance plan you purchase, or the specific options included with your policy. The agent can receive compensation by:

1. Commissions when a policy is purchased or renewed
2. Fees for marketing and administrative services
3. Educational opportunities

Some agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses.

We may also offer incentive trips or prizes associated with sales contests based on sales criteria. Types of sales criteria include overall sales volume of an agent or intermediary with our companies or percentage of completed sales.

Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

Section 9. Applicant(s) Agreement

This agreement is to acknowledge that I am applying for an insurance policy from Tier One Insurance Company that will be issued based on my answers to the questions on this application. I have read, or had read to me, and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are all accurate, complete and correctly documented. I understand that I will receive a copy of the signed application. I acknowledge that I have received an outline of coverage for the policy that I applied for, along with a copy of Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.

I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant.

I understand that upon acceptance of the completed application, each applicant will receive a separate policy with a copy of this application attached.

I understand and agree that this application and any policy issued will be the entire contract of insurance. The Company will not be bound by any statements, promises, or information made or given by any agent or other person at any time unless it is in writing, submitted to the Company's home office, and made a part of the contract of insurance. An Officer of the Company is the only one who can make, modify or discharge contracts or waive any of the Company's rights or requirements; and any modifications must be documented in writing.

I also understand that I do not have coverage until this application is approved, the first premium is paid, there has been no change in my health as stated in the application, and a policy has been issued by the Company.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

If you are at least sixty-five (65) years of age but no more than seventy-five (75) years of age and have an existing Tier One Medicare supplement policy, you're entitled to an annual open enrollment period lasting forty-five (45) days, commencing with your birthday, and you may purchase any Medicare supplement policy issued by Tier One Insurance Company that offers benefits equal to or lesser than those provided by your existing policy. During this open enrollment period, Tier One shall not deny or condition the issuance or effectiveness of Medicare supplemental coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or a medical condition of the individual.

I understand that if any answers on this application are incorrect, incomplete or untrue, Tier One Insurance Company has the right to adjust my premium or cancel the policy.

Applicant A signature

Date signed

X

Applicant B signature

Date signed

X

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison or any combination thereof.

Complete this section *if you are requesting electronic funds transfer (EFT) for premium payment.*
Include a voided check with the application.

Section 10. Account Information – Applicant A

Applicant A name

Account Owner name (if different than proposed insured's)

Account Owner relationship to proposed insured

- ☐ Business owned by proposed insured ☐ Living trust ☐ Employer
☐ Power of Attorney ☐ Conservator/guardian ☐ Family member; please specify:

Financial institution name

Account type

- ☐ Checking ☐ Savings

Routing number

Account number

Section 10. Account Information – Applicant B

Applicant B name

Account Owner name (if different than proposed insured's)

Account Owner relationship to proposed insured

- ☐ Business owned by proposed insured ☐ Living trust ☐ Employer
☐ Power of Attorney ☐ Conservator/guardian ☐ Family member; please specify:

Financial institution name

Account type

- ☐ Checking ☐ Savings

Routing number

Account number

Section 11. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Account owner signature – Applicant A

Date signed

X

Account owner signature – Applicant B

Date signed

X

Section 12. Agent Information

Please list any other medical or health insurance policies sold to Applicant A.

1. List policies sold which are still in force

2. List policies sold in the past 5 years which are no longer in force

Please list any other medical or health insurance policies sold to Applicant B.

1. List policies sold which are still in force

2. List policies sold in the past 5 years which are no longer in force

I certify that:

1. I have truly and accurately recorded the information supplied by the applicant(s).
2. The application was provided to the applicant(s) to review and the applicant(s) has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy(ies).
3. I have provided an outline of coverage for the policy(ies) applied for and A Guide to Health Insurance for People with Medicare to applicant(s) prior to completing the application.

All information must be completed. The writing number reflects where commissions will be paid.

Agent name (printed)

Agent signature

X

Writing number (agent or company)

State license ID number (for FL only)

Phone

Email

Section 13. Agent request to split commissions

If this application results in an issued policy through Tier One Insurance Company (TOIC), the agents listed below have agreed to split the commissions earned on the policy.

1. Both agents must be properly licensed and appointed with TOIC in the policy's state of issue.
2. Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force.
3. The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
4. Calculation of each agent's commissions are based on their respective TOIC commission schedule.

Writing agent name (printed)

Percentage

%

Secondary agent (printed)

Writing number

Percentage

%

Writing agent signature

X

This section must be completed with this application in order to split commissions.

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.



Underwritten by Tier One Insurance Company

Home Office: 1932 Wynnton Road, Columbus, GA 31999

Administrative Office: 1021 Reams Fleming Blvd., Franklin, TN 37064

Telephone Number: 1-833-504-0336 Website: www.Aflac.com

Applicant Receipt

Thank you!

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to Tier One Insurance Company.
- **DO NOT** make any check payable to the agent and **DO NOT** leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

Applicant A *(printed)*

Date of application

Initial payment collected *(if applicable)*

Payment Type

☐ Check ☐ Money order

EFT draft amount

EFT draft date

\$

Applicant B *(printed)*

Date of application

Initial payment collected *(if applicable)*

Payment Type

☐ Check ☐ Money order

EFT draft amount

EFT draft date

\$

This acknowledges receipt of your application for Tier One Insurance Company Medicare Supplement insurance policy.

Agent name *(printed)*

Agent signature

X

Phone

Email

Thank you for choosing Aflac!