HEARTLAND NATIONAL
LIFE INSURANCE COMPANY
Medicare Supplement Administrative Office:
PO Box 10812, Clearwater, FL 33757-8812

APPLICATION FOR
MEDICARE SUPPLEMENT INSURANCE

COLORADO

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Outline of Medicare Supplement Coverage

Benefit Plans A, D, F, G, M, and N

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Plans E, H, I, and J are no longer available for sale.

Basic Benefits:

- **Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.**
- **Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.**
- **Blood – First three pints of blood each year.**
- **Hospice – Part A coinsurance**

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100 % Part B coinsurance except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100 %)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out- of-pocket limit $4640 paid at 100% after limit reached	Out-of -Pocket limit $2320 paid at 100% after limit reached		

***Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2000 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the Policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

Effective 02-14-2011

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

One-Time Policy Fee $25

COLORADO Standard Plans MALE Rates - ANNUAL

For use in zip codes: All zips except 800-802

Attained Age	Non-Tobacco User					
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	1,367	1,762	1,974	1,791	1,647	1,411
65	1,048	1,318	1,526	1,340	1,233	1,062
66	1,097	1,384	1,593	1,407	1,296	1,114
67	1,147	1,451	1,661	1,474	1,357	1,164
68	1,191	1,513	1,722	1,538	1,415	1,214
69	1,234	1,576	1,784	1,601	1,473	1,263
70	1,278	1,638	1,847	1,665	1,531	1,312
71	1,321	1,700	1,909	1,729	1,588	1,363
72	1,367	1,762	1,974	1,791	1,647	1,411
73	1,397	1,816	2,028	1,845	1,695	1,455
74	1,428	1,868	2,080	1,899	1,743	1,500
75	1,459	1,922	2,134	1,953	1,792	1,545
76	1,490	1,974	2,186	2,008	1,840	1,589
77	1,521	2,028	2,242	2,060	1,887	1,632
78	1,538	2,070	2,286	2,104	1,925	1,671
79	1,555	2,113	2,329	2,147	1,963	1,710
80	1,570	2,155	2,373	2,191	2,000	1,749
81	1,587	2,197	2,416	2,234	2,038	1,787
82	1,606	2,242	2,457	2,276	2,077	1,824
83	1,617	2,279	2,495	2,313	2,111	1,859
84	1,627	2,317	2,532	2,351	2,145	1,894
85	1,638	2,355	2,570	2,389	2,180	1,930
86	1,648	2,393	2,608	2,426	2,213	1,965
87	1,661	2,431	2,646	2,466	2,247	2,002
88	1,668	2,442	2,658	2,479	2,258	2,012
89	1,676	2,454	2,672	2,491	2,270	2,022
90	1,685	2,465	2,684	2,504	2,282	2,033
91	1,693	2,478	2,697	2,518	2,293	2,043
92	1,701	2,490	2,711	2,530	2,306	2,055
93	1,710	2,503	2,724	2,543	2,317	2,065
94	1,718	2,517	2,739	2,556	2,329	2,076
95	1,726	2,529	2,753	2,569	2,340	2,086
96	1,734	2,542	2,767	2,582	2,353	2,097
97	1,742	2,555	2,781	2,595	2,364	2,107
98	1,751	2,568	2,796	2,608	2,376	2,118
99	1,759	2,581	2,809	2,620	2,388	2,128

Attained Age	Tobacco User					
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	1,519	1,957	2,193	1,990	1,829	1,567
65	1,164	1,463	1,695	1,489	1,370	1,180
66	1,219	1,538	1,770	1,564	1,440	1,237
67	1,274	1,612	1,845	1,639	1,508	1,293
68	1,324	1,682	1,914	1,710	1,572	1,348
69	1,373	1,751	1,984	1,780	1,638	1,403
70	1,422	1,820	2,053	1,850	1,703	1,456
71	1,472	1,889	2,123	1,922	1,768	1,511
72	1,519	1,957	2,193	1,990	1,829	1,567
73	1,553	2,017	2,253	2,050	1,883	1,617
74	1,587	2,076	2,313	2,110	1,935	1,666
75	1,622	2,135	2,374	2,170	1,989	1,715
76	1,655	2,193	2,434	2,230	2,041	1,764
77	1,691	2,253	2,491	2,289	2,097	1,814
78	1,710	2,300	2,540	2,337	2,139	1,856
79	1,729	2,348	2,588	2,385	2,182	1,898
80	1,748	2,395	2,636	2,434	2,224	1,941
81	1,767	2,442	2,684	2,482	2,267	1,983
82	1,784	2,491	2,731	2,529	2,308	2,027
83	1,797	2,533	2,773	2,571	2,346	2,067
84	1,808	2,576	2,816	2,614	2,383	2,106
85	1,820	2,618	2,857	2,656	2,421	2,146
86	1,832	2,661	2,899	2,698	2,459	2,186
87	1,845	2,701	2,940	2,741	2,496	2,224
88	1,855	2,714	2,954	2,755	2,509	2,234
89	1,864	2,728	2,970	2,769	2,522	2,245
90	1,874	2,742	2,984	2,783	2,534	2,257
91	1,883	2,757	3,000	2,798	2,548	2,269
92	1,892	2,770	3,015	2,811	2,561	2,281
93	1,902	2,784	3,031	2,826	2,573	2,292
94	1,911	2,799	3,046	2,840	2,587	2,305
95	1,921	2,812	3,061	2,854	2,599	2,316
96	1,930	2,827	3,077	2,868	2,613	2,328
97	1,940	2,841	3,091	2,883	2,626	2,339
98	1,949	2,855	3,107	2,896	2,638	2,351
99	1,957	2,869	3,123	2,911	2,652	2,363

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: .08333

Effective 02-14-2011

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

One-Time Policy Fee $25

COLORADO Standard Plans MALE Rates - ANNUAL

For use in zip codes: 800-802

Attained Age	Non-Tobacco User						Attained Age	Tobacco User					
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N		Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	1,529	1,971	2,208	2,003	1,842	1,577	0-64	1,699	2,189	2,452	2,225	2,045	1,752
65	1,172	1,474	1,706	1,499	1,379	1,188	65	1,302	1,636	1,896	1,665	1,533	1,319
66	1,227	1,548	1,781	1,574	1,449	1,246	66	1,363	1,720	1,979	1,748	1,610	1,383
67	1,283	1,622	1,857	1,649	1,518	1,302	67	1,425	1,802	2,063	1,833	1,686	1,446
68	1,332	1,692	1,926	1,720	1,582	1,358	68	1,480	1,881	2,140	1,912	1,758	1,508
69	1,380	1,762	1,996	1,791	1,647	1,413	69	1,535	1,958	2,219	1,991	1,832	1,569
70	1,429	1,832	2,065	1,862	1,712	1,468	70	1,590	2,035	2,296	2,069	1,904	1,629
71	1,478	1,901	2,135	1,933	1,776	1,524	71	1,646	2,113	2,374	2,149	1,977	1,690
72	1,529	1,971	2,208	2,003	1,842	1,577	72	1,699	2,189	2,452	2,225	2,045	1,752
73	1,562	2,030	2,268	2,063	1,896	1,627	73	1,737	2,255	2,520	2,293	2,105	1,808
74	1,597	2,089	2,326	2,124	1,949	1,677	74	1,775	2,321	2,587	2,360	2,164	1,863
75	1,631	2,149	2,386	2,184	2,004	1,727	75	1,813	2,387	2,654	2,426	2,224	1,918
76	1,666	2,208	2,445	2,245	2,058	1,777	76	1,851	2,452	2,722	2,494	2,283	1,973
77	1,701	2,268	2,507	2,304	2,110	1,825	77	1,891	2,520	2,786	2,560	2,345	2,028
78	1,720	2,315	2,556	2,352	2,153	1,868	78	1,912	2,572	2,840	2,613	2,392	2,075
79	1,738	2,362	2,605	2,401	2,195	1,912	79	1,933	2,626	2,894	2,667	2,440	2,123
80	1,756	2,410	2,653	2,450	2,236	1,956	80	1,954	2,678	2,948	2,722	2,487	2,170
81	1,775	2,457	2,702	2,498	2,279	1,998	81	1,976	2,731	3,001	2,776	2,535	2,218
82	1,796	2,507	2,748	2,545	2,323	2,039	82	1,996	2,786	3,054	2,828	2,581	2,266
83	1,808	2,548	2,791	2,587	2,361	2,079	83	2,009	2,833	3,101	2,875	2,623	2,311
84	1,820	2,591	2,832	2,630	2,399	2,118	84	2,022	2,880	3,149	2,923	2,664	2,355
85	1,832	2,633	2,874	2,672	2,437	2,158	85	2,035	2,928	3,195	2,970	2,707	2,400
86	1,843	2,676	2,917	2,713	2,475	2,198	86	2,049	2,975	3,242	3,018	2,749	2,445
87	1,857	2,718	2,959	2,758	2,512	2,239	87	2,063	3,020	3,287	3,065	2,792	2,487
88	1,866	2,731	2,973	2,772	2,525	2,250	88	2,074	3,035	3,303	3,081	2,806	2,498
89	1,874	2,744	2,988	2,786	2,538	2,261	89	2,084	3,050	3,321	3,096	2,820	2,511
90	1,884	2,757	3,001	2,801	2,552	2,274	90	2,095	3,066	3,337	3,113	2,834	2,523
91	1,893	2,771	3,016	2,815	2,565	2,285	91	2,105	3,083	3,355	3,129	2,849	2,537
92	1,902	2,784	3,031	2,829	2,578	2,298	92	2,115	3,098	3,372	3,144	2,864	2,551
93	1,912	2,799	3,046	2,844	2,591	2,309	93	2,127	3,114	3,390	3,160	2,878	2,563
94	1,921	2,814	3,063	2,858	2,605	2,321	94	2,137	3,130	3,406	3,176	2,893	2,577
95	1,931	2,828	3,079	2,873	2,617	2,333	95	2,148	3,145	3,423	3,191	2,907	2,590
96	1,939	2,843	3,094	2,888	2,631	2,345	96	2,158	3,161	3,441	3,207	2,922	2,603
97	1,948	2,857	3,110	2,902	2,643	2,356	97	2,169	3,177	3,457	3,224	2,937	2,616
98	1,958	2,872	3,126	2,917	2,657	2,369	98	2,179	3,192	3,474	3,239	2,950	2,630
99	1,967	2,887	3,141	2,930	2,671	2,380	99	2,189	3,209	3,492	3,255	2,965	2,642

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: .08333

Effective 02-14-2011

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

One-Time Policy Fee $25

COLORADO Standard Plans FEMALE Rates - ANNUAL

For use in zip codes: All zips except 800-802

Attained Age	Non-Tobacco User					
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	1,190	1,533	1,718	1,558	1,433	1,226
65	912	1,147	1,328	1,165	1,072	924
66	954	1,204	1,386	1,224	1,127	969
67	998	1,262	1,444	1,283	1,181	1,013
68	1,036	1,316	1,499	1,339	1,232	1,056
69	1,075	1,370	1,553	1,394	1,282	1,098
70	1,114	1,425	1,607	1,450	1,333	1,141
71	1,153	1,479	1,662	1,504	1,384	1,183
72	1,190	1,533	1,718	1,558	1,433	1,226
73	1,216	1,579	1,764	1,605	1,475	1,266
74	1,243	1,625	1,812	1,652	1,518	1,305
75	1,270	1,671	1,859	1,699	1,560	1,344
76	1,298	1,716	1,906	1,747	1,603	1,383
77	1,324	1,763	1,951	1,792	1,643	1,420
78	1,339	1,801	1,989	1,829	1,675	1,453
79	1,354	1,839	2,027	1,867	1,709	1,485
80	1,369	1,877	2,063	1,905	1,741	1,519
81	1,385	1,914	2,101	1,943	1,774	1,551
82	1,397	1,950	2,138	1,981	1,807	1,587
83	1,407	1,983	2,171	2,013	1,837	1,618
84	1,416	2,015	2,204	2,047	1,866	1,648
85	1,426	2,049	2,238	2,079	1,896	1,678
86	1,435	2,081	2,270	2,113	1,925	1,710
87	1,444	2,115	2,302	2,146	1,954	1,741
88	1,452	2,125	2,313	2,157	1,964	1,750
89	1,459	2,136	2,326	2,167	1,973	1,758
90	1,465	2,146	2,337	2,178	1,983	1,767
91	1,473	2,157	2,349	2,188	1,992	1,776
92	1,480	2,167	2,360	2,200	2,002	1,784
93	1,487	2,178	2,373	2,210	2,012	1,795
94	1,494	2,188	2,384	2,221	2,022	1,803
95	1,501	2,200	2,396	2,231	2,033	1,814
96	1,508	2,210	2,407	2,242	2,043	1,822
97	1,516	2,221	2,419	2,253	2,055	1,832
98	1,522	2,231	2,432	2,265	2,065	1,841
99	1,529	2,242	2,443	2,277	2,076	1,850

Attained Age	Tobacco User					
	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	1,321	1,704	1,908	1,731	1,591	1,364
65	1,012	1,274	1,475	1,296	1,192	1,027
66	1,060	1,338	1,540	1,360	1,252	1,076
67	1,108	1,403	1,605	1,426	1,312	1,126
68	1,151	1,462	1,666	1,487	1,368	1,173
69	1,193	1,522	1,728	1,548	1,423	1,220
70	1,235	1,582	1,789	1,609	1,479	1,267
71	1,278	1,643	1,849	1,671	1,535	1,314
72	1,321	1,704	1,908	1,731	1,591	1,364
73	1,350	1,755	1,961	1,782	1,639	1,406
74	1,379	1,807	2,012	1,835	1,686	1,449
75	1,410	1,859	2,063	1,886	1,733	1,491
76	1,439	1,911	2,116	1,938	1,780	1,533
77	1,471	1,961	2,167	1,991	1,825	1,578
78	1,487	2,002	2,209	2,033	1,861	1,615
79	1,503	2,042	2,250	2,076	1,898	1,653
80	1,520	2,084	2,291	2,118	1,934	1,691
81	1,537	2,125	2,332	2,161	1,971	1,729
82	1,553	2,167	2,375	2,201	2,009	1,763
83	1,564	2,204	2,412	2,238	2,041	1,798
84	1,575	2,241	2,447	2,273	2,075	1,832
85	1,585	2,277	2,484	2,310	2,107	1,866
86	1,596	2,313	2,521	2,347	2,140	1,901
87	1,605	2,349	2,559	2,384	2,171	1,935
88	1,613	2,360	2,571	2,396	2,182	1,945
89	1,622	2,373	2,585	2,407	2,192	1,954
90	1,629	2,384	2,597	2,419	2,203	1,964
91	1,638	2,396	2,610	2,432	2,213	1,973
92	1,646	2,407	2,624	2,443	2,224	1,983
93	1,654	2,419	2,636	2,455	2,234	1,992
94	1,663	2,432	2,649	2,466	2,245	2,002
95	1,671	2,443	2,662	2,479	2,257	2,012
96	1,678	2,455	2,675	2,491	2,269	2,022
97	1,687	2,466	2,688	2,504	2,281	2,033
98	1,695	2,479	2,701	2,518	2,292	2,043
99	1,704	2,491	2,714	2,530	2,305	2,055

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: .08333

Effective 02-14-2011

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

One-Time Policy Fee $25

COLORADO Standard Plans FEMALE Rates - ANNUAL

For use in zip codes: 800-802

Attained	Non-Tobacco User					
Age	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	1,330	1,715	1,921	1,742	1,602	1,372
65	1,020	1,283	1,485	1,303	1,199	1,033
66	1,067	1,347	1,550	1,369	1,260	1,083
67	1,116	1,411	1,615	1,435	1,320	1,133
68	1,158	1,471	1,676	1,498	1,378	1,181
69	1,202	1,533	1,737	1,559	1,434	1,228
70	1,246	1,594	1,797	1,621	1,490	1,275
71	1,289	1,654	1,858	1,682	1,548	1,323
72	1,330	1,715	1,921	1,742	1,602	1,372
73	1,360	1,766	1,973	1,795	1,650	1,415
74	1,390	1,817	2,027	1,847	1,697	1,459
75	1,420	1,868	2,079	1,899	1,745	1,503
76	1,451	1,919	2,132	1,953	1,792	1,546
77	1,480	1,972	2,182	2,004	1,837	1,587
78	1,498	2,014	2,224	2,045	1,873	1,625
79	1,514	2,057	2,266	2,088	1,911	1,661
80	1,531	2,099	2,308	2,130	1,947	1,699
81	1,549	2,140	2,350	2,173	1,984	1,735
82	1,562	2,180	2,391	2,215	2,021	1,775
83	1,574	2,218	2,427	2,251	2,054	1,810
84	1,584	2,254	2,465	2,289	2,087	1,843
85	1,595	2,291	2,502	2,325	2,120	1,877
86	1,605	2,328	2,538	2,362	2,153	1,912
87	1,615	2,365	2,575	2,400	2,185	1,947
88	1,624	2,376	2,587	2,412	2,196	1,957
89	1,631	2,389	2,601	2,424	2,206	1,966
90	1,639	2,400	2,613	2,436	2,218	1,976
91	1,647	2,412	2,627	2,447	2,228	1,986
92	1,655	2,424	2,640	2,460	2,239	1,996
93	1,662	2,436	2,653	2,471	2,250	2,007
94	1,671	2,447	2,666	2,484	2,261	2,017
95	1,679	2,460	2,679	2,495	2,274	2,028
96	1,686	2,471	2,692	2,507	2,285	2,038
97	1,695	2,484	2,706	2,520	2,298	2,049
98	1,702	2,495	2,719	2,533	2,309	2,059
99	1,710	2,507	2,732	2,546	2,321	2,069

Attained	Tobacco User					
Age	Plan A	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	1,478	1,906	2,134	1,936	1,780	1,525
65	1,132	1,425	1,650	1,449	1,333	1,148
66	1,186	1,496	1,722	1,521	1,400	1,203
67	1,239	1,569	1,795	1,595	1,468	1,259
68	1,287	1,635	1,863	1,662	1,530	1,312
69	1,334	1,702	1,932	1,731	1,591	1,364
70	1,382	1,770	2,001	1,800	1,654	1,416
71	1,429	1,837	2,068	1,868	1,716	1,469
72	1,478	1,906	2,134	1,936	1,780	1,525
73	1,510	1,963	2,193	1,993	1,833	1,572
74	1,543	2,021	2,250	2,052	1,886	1,620
75	1,576	2,079	2,308	2,109	1,938	1,667
76	1,609	2,137	2,366	2,168	1,991	1,715
77	1,645	2,193	2,424	2,226	2,040	1,765
78	1,662	2,239	2,470	2,274	2,082	1,806
79	1,681	2,284	2,516	2,321	2,123	1,848
80	1,700	2,330	2,562	2,369	2,163	1,891
81	1,718	2,376	2,608	2,416	2,204	1,933
82	1,737	2,424	2,656	2,461	2,246	1,972
83	1,748	2,465	2,697	2,502	2,283	2,011
84	1,761	2,506	2,737	2,542	2,320	2,049
85	1,772	2,546	2,778	2,583	2,356	2,087
86	1,785	2,587	2,819	2,625	2,394	2,125
87	1,795	2,627	2,862	2,666	2,427	2,164
88	1,803	2,640	2,875	2,679	2,440	2,175
89	1,813	2,653	2,890	2,692	2,451	2,185
90	1,822	2,666	2,904	2,706	2,464	2,196
91	1,832	2,679	2,919	2,719	2,475	2,206
92	1,841	2,692	2,934	2,732	2,487	2,218
93	1,850	2,706	2,948	2,746	2,498	2,228
94	1,860	2,719	2,963	2,758	2,511	2,239
95	1,868	2,732	2,976	2,772	2,523	2,250
96	1,877	2,746	2,991	2,786	2,537	2,261
97	1,887	2,758	3,006	2,801	2,551	2,274
98	1,896	2,772	3,020	2,815	2,563	2,285
99	1,906	2,786	3,035	2,829	2,577	2,298

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: .08333

PREMIUM INFORMATION

Heartland National Life Insurance Company may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as attained age, sex, underwriting class, state and zip code of residence.

Premiums are based on your attained age and will change on Your Policy Anniversary Date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of Policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your Policy's most important features. The Policy is your insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and Heartland National Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your Policy, you may return it to: Heartland National Life Insurance Company, Medicare Supplement Administration, P.O. Box 10814**,** Clearwater, Florida 33757-8814**.** If you send the Policy back to us within 30 days after you receive it, we will treat the Policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This Policy may not fully cover all of your medical costs. Neither Heartland National Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new Policy, be sure to answer truthfully and completely all questions about your medical and health history. Heartland National Life Insurance Company may cancel your Policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your Policy for details.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1132	$0	$1132 (Part A deductible)
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
— Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $141.50 a day	$0	Up to $141.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1132	$1132 (Part A deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $162 (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1132	$1132 (Part A deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
— Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $162 of Medicare Approved Amounts*	$0	$162 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare Approved amounts*	$0	$162 (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment First $162 of Medicare Approved Amounts*	$0	$162 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1132	$1132 (Part A deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed $162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment First $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum

PLAN M

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1132	$566 (50% of Part A deductible)	$566 (50% of Part A deductible)
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN M

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $162 (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1132	$1132 (Part A deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $162 (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

HEARTLAND NATIONAL LIFE INSURANCE COMPANY
Home Office: Indianapolis, Indiana 46280
Medicare Supplement Administrative Office: PO Box 10812, Clearwater, FL 33757-8812

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

Application #:	
Applicant **(Exactly as shown on your Medicare ID Card)**	Residence Address:
Last	Street
First MI	City
Indicate the Medicare Supplement Plan Applied for:	State Zip Code
Plan: _____	Phone: (_____) _____ - _____

SOCIAL SECURITY NUMBER	MEDICARE CLAIM NUMBER

AGE	DATE OF BIRTH	GENDER	HEIGHT	WEIGHT
	Month Day Year	☐ Male ☐ Female	_____ ft _____ in	_____ lbs

PREMIUM PAYMENT

Modal Premium: $ _____ Policy Fee: $ _____

Total Submitted Premium: $ _____ Requested Effective Date: _____

or ☐ Draft Initial Premium

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

☐ I authorize Bank Draft payments. Account Type: ☐ Checking ☐ Savings Amount to be drafted: $ _____

Bank Routing # (9 digits): _____ Bank Account # (do not include check #): _____ Select Bank Draft Day: (Cannot be more than 10 days beyond effective day) _____

Bank Name: _____

Name(s) of Depositor(s): _____

Signature of Depositor: _____ Date: _____

Please include a voided check on a separate sheet of paper.

PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

1. Have you used tobacco in any form in the past 12 months? Yes ☐ No ☐

2. Are you covered under Medicare Part A? Yes ☐ No ☐

   If YES, what is your Part A effective date? _____/_____/_____

   If NO, what is your eligibility date? _____/_____/_____

3. Are you covered under Medicare Part B? Yes ☐ No ☐

   If YES, what is your Part B effective date? _____/_____/_____

   If NO, what is your eligibility date? _____/_____/_____

4. Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility). Yes ☐ No ☐

MEDICARE & INSURANCE INFORMATION (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 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 our application. **PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X".**

To the best of your knowledge:

1. Did you turn age 65 in the last six months? ☐ Yes ☐ No
2. Did you enroll in Medicare Part B in the last six months? ☐ Yes ☐ No
   If "Yes", what is the effective date? _____/_____/_____
3. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No
   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, answer a-b below.
   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No
4. (a) If you had coverage from any Medicare plan other than original Medicare within the past 6 months (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. (If you are still covered under the other policy, leave "END" blank.) Start ____/____/____ End ____/____/____

   If YES, with which company _____

   Company telephone number: _____ Policy number: _____

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No
   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   (d) Did you drop a Medicare Supplement plan to enroll in this Medicare plan? ☐ Yes ☐ No
   (e) Has your coverage under the previous plan been involuntarily terminated for reasons other than nonpayment of premium or fraud? ☐ Yes ☐ No

MEDICARE & INSURANCE INFORMATION (Continued)

5. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

   (b) If yes with which company: _____

   with which plan: _____

   what paid-to-date do you have? _____/_____/_____

   Company telephone number: _____

   (c) If yes, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

6. Have you had coverage under any other health insurance within the past 6 months (for example, an employer, union, or individual plan)? ☐ Yes ☐ No

   (a) If yes, with which company :_____

   what kind of policy_____

   what paid-to-date do you have? _____/_____/_____

   Company telephone number: _____

   (b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.) Start ____/_____/_____ End ____/_____/_____

   (c) Has coverage under a previous policy been involuntarily terminated for reasons other than nonpayment of premiums or fraud? ☐ Yes ☐ No

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

(1) You do not need more than one Medicare Supplement Insurance 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 Insurance Policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance 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 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 a Medicare Supplement Insurance policy 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).

HEALTH QUESTIONS

Do not answer health questions 1-15 if you are in an open enrollment or guaranteed issue period. Please see page 6 for an explanation of open enrollment /guaranteed issue period information.

NOTICE TO APPLICANT: Please answer all of the following questions. Please verify the accuracy and completeness of the medical information on this application. Incomplete or false information on this application could jeopardize future claims. If you answer YES to any of the following questions 1 - 14, you are not eligible for coverage.

1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? Yes ☐ No ☐
2. Have you been diagnosed with emphysema, chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disorders? Yes ☐ No ☐
3. Have you been diagnosed with Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with fractures, cirrhosis or kidney disease requiring dialysis? Yes ☐ No ☐
4. Have you been diagnosed with Alzheimer's disease, senile dementia, or any other cognitive disorder? Yes ☐ No ☐
5. Have you been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)? Yes ☐ No ☐
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), or kidney disease? If you do **not** have diabetes, this question should be answered "NO." Yes ☐ No ☐
7. Do you have diabetes that has ever required more than 50 units of insulin daily? Yes ☐ No ☐
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? Yes ☐ No ☐
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? Yes ☐ No ☐
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes ☐ No ☐
11. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts? Yes ☐ No ☐
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes ☐ No ☐
13. Have you been hospital confined three or more times in the last two years? Yes ☐ No ☐
14. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes ☐ No ☐

HEALTH QUESTIONS Continued	
15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If YES, please list the drug(s) below along with the date prescribed, dosage/frequency and diagnosis/medical condition for **each** medication. Attach a separate sheet if needed.	Yes ☐ No ☐

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/ Medical Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	

PRIMARY CARE PHYSICIAN INFORMATION

Physician's Name: ____

Telephone Number: ____

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-15 on pages 4 and 5 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

(a) Enrolled under an employee welfare benefit plan that either: (1) provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or (2) 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; or

(b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation; or

(e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment; or

(f) Upon *first* becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months.

Documentation of these events must be submitted with the application. To qualify as an eligible person you must apply within 63 days of the date of a voluntary termination (other than for nonpayment of premiums or fraud) and within 6 months of the date of an involuntary termination.

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

Agent #1 Signature	Date	
Agent #1 Name (please print)	Agent #	Split %
Agent #2 Signature	Date	
Agent #2 Name (please print)	Agent #	Split %

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Heartland National Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Heartland National Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Heartland National Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Heartland National Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Heartland National Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Heartland National Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 10812, Clearwater, Florida 33757-8812. I understand that such revocation will not have any effect on actions Heartland National Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at: _____ _____ _____

State | Applicant's Signature | Date

This section to be completed by an agent.

Signed at: _____ _____ _____

State | Writing Agent's Signature and Agent Number | Date

Policy Mailing Preference: ☐ Mail to Agent ☐ Mail to Applicant

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: Indianapolis, Indiana 46280
Medicare Supplement Administrative Office: P. O. Box 10812 Clearwater, Florida 33757-8812

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 Heartland National Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums
- ☐ Fewer benefits and lower premiums.
- ☐ Change in benefits (Gaining additional benefit(s), but losing some existing benefit(s)).
- ☐ 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) _____

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent, Broker or Other Representative	Agent's Printed Name and Address

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature	Date

MSREPL2010

Return to Company.

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Heartland National Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Heartland National Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Heartland National Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Heartland National Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Heartland National Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Heartland National Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 10812, Clearwater, Florida 33757-8812. I understand that such revocation will not have any effect on actions Heartland National Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at: _____ _____ _____

State | Applicant's Signature | Date

This section to be completed by an agent.

Signed at: _____ _____ _____

State | Writing Agent's Signature and Agent Number | Date

Policy Mailing Preference: ☐ Mail to Agent ☐ Mail to Applicant

Leave with Applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

HEARTLAND NATIONAL LIFE INSURANCE COMPANY

Home Office: Indianapolis, Indiana 46280
Medicare Supplement Administrative Office: P. O. Box 10812 Clearwater, Florida 33757-8812

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You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums
- ☐ Fewer benefits and lower premiums.
- ☐ Change in benefits (Gaining additional benefit(s), but losing some existing benefit(s)).
- ☐ 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) _____

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Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent, Broker or Other Representative	Agent's Printed Name and Address

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature	Date

MSREPL2010

Leave with Applicant.

RECEIPT

All premium checks must be payable to: **Heartland National Life Insurance Company**. Do not make checks payable to the agent or leave the Payee blank.
EFFECTIVE DATE will be the date of the application or the date of approval.

Received from _____

the sum of $ _____ **dollars for** _____**months premium, with application.** If for any reason the application is not approved and the policy is not issued, this premium is to be refunded. No liability is created or assumed by the Company, except for refund of this premium, until the policy applied for has been issued.

Date Receipt and Outline of Coverage was prepared _____

By (Agent's Signature) _____