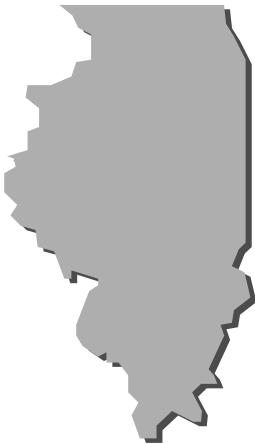


# First Diagnosis Cancer

Insurance Application



# UNITED TEACHER ASSOCIATES INSURANCE COMPANY

P.O. BOX 559015 • AUSTIN, TEXAS 78755-9015

## APPLICATION FOR FIRST DIAGNOSIS CANCER BENEFIT POLICY

		<input type="checkbox"/> <b>New Business</b> <input type="checkbox"/> <b>Reinstatement</b> <input type="checkbox"/> <b>Benefit Change</b>			PV Case# _____		
County Name:	County Number:	Month	Date of Birth Day	Year	Sex	Height	Weight
Applicant:							
Spouse:						X	X
Child #1:						Full Time Student?	Yes No
Child #2:						Full Time Student?	Yes No
Child #3:						Full Time Student?	Yes No
Applicant's Street Address:			City:	State:	Zip Code:		
Applicant's Mailing Address: (If different from above)			City:	State:	Zip Code:		
Payer's Name:	Relationship:	Payer's Address:					
Applicant's Social Security # :		Occupation:					
Beneficiary (full name):		Relationship:	Job Duties:				
Employer's Name:	Employer's Address:						
Home telephone # :	( )	Work telephone # :	( )	Best time to call			
<input type="checkbox"/> Individual <input type="checkbox"/> Single Parent <input type="checkbox"/> Family		Premium Payment Mode:					
<b>First Diagnosis Cancer Benefit Policy</b>		Benefit Amount: \$	Modal Premium		\$		
<input type="checkbox"/> <i>Intensive Care Unit Benefit Rider</i>		Benefit Amount: \$	per day	Rider Premium	\$		
<input type="checkbox"/> <i>Return of Premium Rider (Maximum Issue Age is 60)</i>				Rider Premium	\$		
<input type="checkbox"/> <i>First Diagnosis Heart Attack &amp; First Major Heart Surgery Rider (Maximum Issue Age is 64)</i>		Benefit Amount: \$	Rider Premium		\$		
<input type="checkbox"/> <b>Other</b>		Specify rider type and benefit amount (if applicable):		no other rider available	Rider Premium	\$	
<b>FOR PAYROLL DEDUCTION:</b>							
Group Name:				Enrollment Fee	\$		
Group Number:	Is this Section #125?	<input type="checkbox"/> Yes <input type="checkbox"/> No	TOTAL PREMIUM		\$		

1. Is the insurance applied for here intended to replace any existing insurance? If yes, list name of Company and policy number:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**MEDICAL INFORMATION. Answer all questions and circle the applicable conditions.**

2. Have you or any person to be insured under this policy ever had a test to determine if cancer is present where the results are pending or are other than normal? <i>If Yes, who?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please describe the results. _____	
3. Have you or any person to be insured under this policy ever been treated for or had symptoms of Internal Cancer, Melanoma, Malignant Growth, Sarcoma, or any type of Cancer, except non-melanoma skin cancer or had elevated PSA levels greater than 4.0? <i>If Yes, who?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the answer is Yes, any individual named will be excluded from coverage.	
4. Have you or any person to be insured under this policy ever been treated for or had symptoms of Skin Cancer, excluding Melanoma? <i>If Yes, who?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please describe the condition and treatment period. _____	
5. Have you or any person to be insured under this policy ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive on an AIDS-related (Human Immunodeficiency Virus "HIV") blood test? <i>If "Yes", who?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the answer is Yes, any individual named will be excluded from coverage under this policy.	
6. Have you or any person to be insured under this policy ever been treated for or had symptoms of Dysplasia of the uterus? Please describe the level diagnosed.	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PLEASE ANSWER QUESTIONS #7 & #8 IF YOU ARE APPLYING FOR THE INTENSIVE CARE UNIT BENEFIT RIDER:**

7. Have you or any person to be insured under the Intensive Care Unit Benefit Rider ever been treated for or had symptoms of diabetes or any disorder, abnormality or condition of the brain, lung, liver, or connective tissue? If Yes, who? _____ <b>If the answer is Yes, any individual named will be excluded from coverage under this rider.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are you or any person to be insured under the Intensive Care Unit Benefit Rider currently pregnant? If Yes, who? _____ <b>If the answer is Yes, any individual named will be excluded from coverage under this rider.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PLEASE ANSWER QUESTIONS 9–12 IF YOU ARE APPLYING FOR THE FIRST DIAGNOSIS HEART ATTACK OR THE INTENSIVE CARE UNIT BENEFIT RIDERS:**

9. Have you or any person to be insured under these riders ever had, ever been treated for, or ever had symptoms of, ever received medical advice for, or taken prescribed medication for uncontrolled high blood pressure? If Yes, who? _____ <b>If the answer is Yes, any individual named will be excluded from coverage under these riders.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you, or any person to be insured under these riders ever had or ever been advised to have: any form of heart surgery, coronary artery surgery, or heart related surgery; or an arteriogram, angioplasty, or pacemaker installed, or within the last 6 months, received medical advice or consultation or had medical tests performed (including those during the course of routine check-ups) where the results were other than normal or are still pending? If Yes, who? _____ <b>If the answer is Yes, any individual named will be excluded from coverage under these riders.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you, or any person to be insured under these riders ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for any disease, disorder or abnormality of the heart or circulatory system (arteries, veins, lymphatic nodes and vessels)? If Yes, who? _____ <b>If the answer is Yes, any individual named will be excluded from coverage under these riders.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you, or any person to be insured under these riders ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for: myocardial infarction or heart attack, stroke or transient ischemic attack (TIA)? If Yes, who? _____ <b>If the answer if Yes, any individual named will be excluded from coverage under these riders.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

I hereby represent that the foregoing answers are recorded as given by me and that the same are true. I represent that all questions on this application were asked and that the answers were properly recorded. I further agree that this insurance applied for shall be subject to the conditions and provisions of the policy and shall not be in force until the application is accepted and the policy issued by the Company. I acknowledge receipt of the Outline of Coverage. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, or The Medical Information Bureau to release any records concerning me or my health to United Teacher Associates Insurance Company and its reinsurers. This authorization will be valid for 24 months from the date the authorization is signed. No agent has the right to waive the answer to any question in this application, to pass on insurability, to waive any of the Company's rights or requirements, or to make or alter any contract. I agree that this application shall form a part of any policy issued. The undersigned applicant and agent represent that the applicant has read or had read to him the completed application and he realizes any false statement or misrepresentation therein which is material to the risk or hazard assumed may result in a loss of coverage under the policy subject to the Time Limit on Certain Defenses and legal proceedings. A photographic copy of this authorization shall be as valid as the original.

*I understand that the "Effective Date" of this policy will be the date recorded on the policy schedule by our office. It is not the date the application was signed. The policy has a 30-day "waiting period" which begins on the "Effective Date" of the policy.*

**I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.**

Note to Agent: Is replacement of insurance involved?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signed at _____ (City and state)	Date: _____
Agent's Signature _____	Writing Number _____
Agent's Printed Name _____	Agent's License Number: _____
	Read and Signed (√) _____ (Applicant's Signature) Check Block if Agent Family Business <input type="checkbox"/>

**UNITED TEACHER ASSOCIATES INSURANCE COMPANY  
PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER**

P.O. Box 559015 | Austin, TX 78755-9015

Proposed Insured's Name

Policy Number (if Available)

Financial Institution Name and Telephone Number

Financial Institution Address

9 Digit Routing Number

Account Number

**Requested Withdrawal Date (1st thru 28th):**

**Withdraw Payment:**     Monthly     Quarterly     Semi-Annually     Annually

**Type of Account:**

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

**Purpose for Submitting this Authorization – Check appropriate box(es):**

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

Name of Employer Group

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

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

**TAPE VOIDED CHECK HERE** 0101

PAY TO THE ORDER OF \_\_\_\_\_ \$ \_\_\_\_\_

Dollars

The Routing number is 9 digits between the **⑆ ⑆** symbols.

**⑆ 123456789 ⑆**

The Account number is usually to the left of **⑆**. If check number is left of account number, ignore check number.

**34567890 ⑆**

The Check number should match the upper right corner.

**0101**

**APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS:** As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to United Teacher Associates Insurance Company (UTA) provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

**PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER**

**APPLICANT INFORMATION FOR THE COMPANY SELECTED ABOVE:** It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract, and no other notice of premiums due will be given. No premium shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium payment has been received by UTA. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by UTA if any draft is not paid upon presentation. The payment of premiums under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by UTA upon 30 days written notice.

Print Name of Depositor (as it appears on account)

Signature of Depositor

Date

# ***UNITED TEACHER ASSOCIATES INSURANCE COMPANY***

*An Old Line Legal Reserve Company*

P.O. Box 26580

Austin, Texas 78755-0580

(512) 451-2224

## **NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**

According to your application and information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by United Teacher Associates Insurance Company. Your new policy provides 10 days in which you may decide, without cost, whether or not you decide to keep this policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, 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/health history. Failure to include all material medical information on any 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, reread it carefully to be certain that all information has been properly recorded.

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

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(Date)

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(Applicant's Signature)

**THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company.**

## ***UNITED TEACHER ASSOCIATES INSURANCE COMPANY***

**P.O. Box 26580 • Austin, Texas 78755-0580**

### ***FIRST DIAGNOSIS CANCER BENEFIT POLICY***

#### **SPECIFIED DISEASE COVERAGE POLICY FORM CF-960201-UTA-IL OUTLINE OF COVERAGE**

**ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.**

**READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of the important features of Your coverage. This is not the insurance contract and only the actual contract provisions of the policy will control the rights and obligations of the parties to it. The policy itself sets forth in detail those rights and obligations applicable to both You and *UNITED TEACHER ASSOCIATES INSURANCE COMPANY*. It is very important therefore, that YOU READ YOUR POLICY CAREFULLY.

**SPECIFIED DISEASE COVERAGE:** Policies of this category are designed to provide, to You, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

**TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND THE PREMIUM REFUNDED:** Ten (10) Day Free Look. After You receive Your policy, take up to ten (10) days to examine Your policy. If You are not completely satisfied, You may return it to Us within ten (10) days and receive a full refund of the premium You paid.

**Caution:** The issuance of the First Diagnosis Cancer Benefit Policy is based upon Your responses to the questions on Your application. A copy of Your application is attached to Your policy when it is issued. If Your answers are incorrect or untrue, We may deny benefits or rescind Your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at: *UNITED TEACHER ASSOCIATES INSURANCE COMPANY*, P.O. Box 26580, Austin, Texas 78755-0580.

#### **AMOUNT OF BENEFITS**

If an Insured receives a First Diagnosis of internal Cancer or malignant melanoma, We will pay the First Diagnosis Cancer Benefit Amount shown on the policy schedule. The First Diagnosis must be after the Waiting Period and while this policy is in force with respect to the Insured. No benefit is payable for diagnosis of skin Cancer other than malignant melanoma. Each Insured is limited to one First Diagnosis Cancer Benefit Amount under the terms of this policy.

#### **LIMITATIONS AND EXCLUSIONS**

This policy provides benefits only for First Diagnosis of internal Cancer or malignant melanoma. This policy does not cover any other disease or sickness or incapacity. No benefit is payable for the diagnosis of skin Cancer other than malignant melanoma. Cancer first diagnosed during the Waiting Period will not be a covered condition.

**TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED**

**RENEWAL CONDITIONS**

Subject to the payment of the First Diagnosis Cancer Benefit Amount, You may renew the policy for life by paying each renewal premium as it becomes due. We do not have the right to cancel the policy except for non-payment of premium, the conditions as stated in the Time Limit On Certain Defenses provision, and/or the payment of the benefit amount.

**PREMIUM CHANGES**

We reserve the right to change premium rates. A change in the rates will apply to all policies of this form in Your state. The change will be effective on the next premium due date of Your policy. If We change the rates, Your premium will be determined by Your age on the Effective Date of the policy. We will write to You at the address shown in Our records, at least thirty (30) days before We change Your premium rate.

**GRACE PERIOD**

The policy has a thirty-one (31) day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, the policy will stay in force.

**OPTIONAL RIDERS - ADDITIONAL PREMIUM REQUIRED**

**FIRST DIAGNOSIS DREAD DISEASE BENEFIT RIDER**

**(Form Number RD-20101-DD-IL)**

This Rider provides the First Diagnosis Dread Disease Benefit amount shown on the policy schedule. The First Diagnosis of a covered Dread Disease must be after the Waiting Period and while this Rider is in force with respect to the Insured. Each Insured is limited to one First Diagnosis Dread Disease Benefit amount under the terms of this Rider.

The Dread Diseases are any of the diseases listed below which are first diagnosed after the Effective Date and after the Waiting Period shown on the policy schedule. The disease must be diagnosed by a Physician based on generally accepted diagnostic criteria. The covered diseases are:

- |                               |                     |                      |                      |
|-------------------------------|---------------------|----------------------|----------------------|
| Muscular Dystrophy            | Tetanus             | Diphtheria           | Tularemia            |
| Legionnaire's Disease         | Tuberculosis        | Sickle Cell Anemia   | Typhoid Fever        |
| Toxic Epidermal Necrolysis    | Osteomyelitis       | Scarlet Fever        | Multiple Sclerosis   |
| Amyotrophic Lateral Sclerosis | Meningitis          | Smallpox             | Epilepsy             |
| Tay-Sachs Disease             | Myasthenia Gravis   | Rheumatic Fever      | Whipple's Disease    |
| Addison's Disease             | Reye's Syndrome     | Toxic Shock Syndrome | Niemann-Pick Disease |
| Encephalitis                  | Lupus Erythematosus | Rabies               | Poliomyelitis        |
| Rocky Mountain Spotted Fever  |                     |                      |                      |

**INTENSIVE CARE UNIT BENEFIT RIDER**

**(Form Number RD-10203-ICU-IL)**

This Rider provides the following benefits:

**ICU Confinement Benefit:** For each calendar day an Insured is medically necessarily confined to an ICU for treatment of an accidental injury or sickness, We will pay the actual ICU charge, payable from the first day of confinement, not to exceed the maximum ICU Benefit shown in the policy schedule. Benefits are not to exceed thirty (30) days for each period of continuous Hospital confinement. Coverage provided for each Insured Child will be equal to one-half of the listed ICU Benefit amount shown on the policy schedule from birth to the Insured Child's first birthday. Upon attainment of age sixty-five (65) coverage for each Insured will reduce to one-half of the listed ICU Benefit amount shown on the policy schedule.

**Government Hospital Benefit:** If You are required to pay the charge of a Government Hospital for intensive care confinement, We will pay the actual charge for each calendar day made by the Hospital not to exceed the daily limit set forth above for any given calendar day.

**Your Total Premium (At time of application):**

First Diagnosis Cancer Benefit Policy		\$ _____
First Diagnosis Dread Disease Benefit Rider		\$N/A
Intensive Care Unit Benefit Rider		\$ _____
<b>\$ _____</b>	<b>+</b>	<b>\$ _____</b>
<b>Policy Premium</b>		<b>Rider Premium</b>
	<b>=</b>	<b>_____</b>
		<b>Total Amount</b>

# ***UNITED TEACHER ASSOCIATES INSURANCE COMPANY***

*An Old Line Legal Reserve Stock Company*

**P.O. Box 26580**

**Austin, Texas 78755-0580**

## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

### **This is not Medicare Supplement Insurance**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnosis named in the policy.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice
- other approved items and services

### **Before You Buy This Insurance**

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.



Supplemental Benefits Group

# New Business FaxApp

For all business except Long-Term Care  
(For LTC applications use form # GALIC-3-0001)

To: Great American Supplemental Benefits Group

Fax #: **877-704-8186**

## AGENT'S INFORMATION (Must be Completed)

FROM:	
PHONE #:	FAX #:
WRITING #:	EMAIL:
DATE:	NUMBER OF PAGES: <span style="float: right;">+ cover</span>

## APPLICANT'S INFORMATION (Must be Completed)

NAME:	SS#:	<input type="checkbox"/> CWA	<input type="checkbox"/> Draft
NAME:	SS#:	<input type="checkbox"/> CWA	<input type="checkbox"/> Draft
NAME:	SS#:	<input type="checkbox"/> CWA	<input type="checkbox"/> Draft
NAME:	SS#:	<input type="checkbox"/> CWA	<input type="checkbox"/> Draft
NAME:	SS#:	<input type="checkbox"/> CWA	<input type="checkbox"/> Draft

**All applications submitted with a single cover sheet must be from the same writing agent.**

### Procedures:

For the fastest service send one application per cover sheet and only one application per transmission. You may send up to five applications with a single cover sheet per transmission. **However, do not exceed 25 pages per transmission.** Simply complete the application and fax the following to **877-704-8186**.

- FaxApp Cover Sheet
- Application in numeric page order
- Any state specific or replacement forms where applicable
- **Copy of the initial premium check if collected from the client at Point-of-Sale or a void check so that we can draft for the initial premium. You must submit one or the other or the application cannot be processed.**

### Instructions:

- Please set your fax machine to receive confirmation to show that your fax went through
- You will receive a confirmation by email verifying that we have received the application. **This confirmation will include the case number.**

### Premium:

- Agents are encouraged to utilize the bank draft authorization to draft for the first premium in lieu of collecting the initial premium from the applicant.
- If you collected initial premium from the applicant **please indicate the case number on the check** and mail the check stapled to the top of the FaxApp cover sheet to:

Imaging-New Business  
P.O. Box 559015, Austin, TX 78755-9015

We must receive the premium within 10 days of receipt of the application. If it is not received within 10 days we will send you a letter stating that the money for the policy must be submitted immediately. If we do not receive the check after 20 days, a letter will be sent stating the policy will be cancelled in 5 days unless we receive payment for the issued policy. **If we do not receive payment after 25 days, a letter will be sent to you and the applicant stating the file has been closed and the policy has been cancelled due to non-payment of premium.**

**The Great American Supplemental Benefits Group Family of companies include:**  
Central Reserve Life, Continental General, Great American Life®, Loyal American Life®,  
Provident American Life & Health and United Teacher Associates Insurance Companies

# **UNITED TEACHER ASSOCIATES INSURANCE COMPANY**

*An Old Line Legal Reserve Stock Company*  
5508 Parkcrest Drive · P.O. Box 26580  
Austin, Texas 78755-0580

## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

### **This is not Medicare Supplement Insurance**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnosis named in the policy.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice
- other approved items and services

### **Before You Buy This Insurance**

- Check the coverage in **all** health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.