Application

Medicare Supplement Insurance

Virginia

Underwritten by

The American Home Life Insurance Company

Home Office: 400 S Kansas Ave., Topeka, KS 66601

www.amhlifeco.com

Application for Medicare Supplement Insurance

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

Section 1a. Applicant A Information

Applicant A name *(as appears on Medicare card*)*
•

Phone
•

Residential address
•

Apt/suite number
•

City
•

State
•

Zip
•

Mailing address *(if different than residential address)*
•

Apt/suite number
•

City
•

State
•

Zip
•

E-mail
•

Social Security Number
•

Birth date *(mm/dd/yyyy)*
•

Age
•

☐ **Male**
☐ **Female**

Are you a legal resident of the United States? ☐ Yes ☐ No

Medicare card number*
•

Effective date: Medicare Part A
•

Medicare Part B
•

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

Section 1b. Applicant B Information

Applicant B name *(as appears on Medicare card*)*
•

Phone
•

Residential address
•

Apt/suite number
•

City

State
•

Zip
•

Mailing address *(if different than residential address)*
•

Apt/suite number
•

City
•

State
•

Zip
•

E-mail
•

Social Security Number
•

Birth date *(mm/dd/yyyy)*
•

Age
•

☐ **Male**
☐ **Female**

Are you a legal resident of the United States? ☐ Yes ☐ No

Medicare card number*
•

Effective date: Medicare Part A
•

Medicare Part B
•

Section 2a. Household Premium Discount Information

Household Premium Discount Eligibility Information

You may qualify for a Medicare Supplement household discount if (1) you reside with your spouse who currently holds or is applying for a Medicare Supplement policy with The American Home Life Insurance Company; or (2) you currently have a household resident (at least one but no more than three) with whom you have continuously resided for the past 12 months who holds or is applying for a Medicare Supplement policy with The American Home Life Insurance Company.

If you are eligible based on the above requirements, the discount will be 7 percent lower than the individual rates and will apply as long as these requirements are met.

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

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

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

Name	Policy number (if applicable)	Relationship to Applicant

Payment Modes

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

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

Section 2b. Plan and Premium Information – Applicant A

Applicant A Plan selected*

☐ Plan A* ☐ Plan F** ☐ Plan G ☐ Plan N

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

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

•

Modal premium	**Modal premium with discount**	**Policy fee*** **	**Total initial premium collected/draft**
$	**$**	**$ 25.00**	**$**

Initial Premium

☐ Draft initial premium upon policy approval ☐ Draft initial premium on the policy effective date

Subsequent draft date****

•

Payment mode

☐ Annually ☐ Quarterly ☐ Semi-annually ☐ Monthly EFT

Initial Premium

☐ Check ☐ EFT ☐ List Bill Billing file identifier:

If applying for household discount, provide the discounted and non-discounted premium amounts.
**Plan A available for applicants younger than age 65 and eligible for Medicare by reason of disability as defined by federal law.*
***Plans A, G and N are available to all applicants. Plan F is available **ONLY** to those first eligible for Medicare before 1/1/2020.*
****This one-time fee will be refunded, along with your premium, if the policy is not issued or you return it during your 30-day free look.*
***** Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 10 days greater than the policy's paid to date will draft a month in advance.*

Section 2b. Plan and Premium Information – Applicant B

Applicant B Plan selected

☐ Plan A* ☐ Plan F** ☐ Plan G ☐ Plan N

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

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

•

Modal premium	**Modal premium with discount**	**Policy fee*** **	**Total initial premium collected/draft**
$	**$**	**$ 25.00**	**$**

Initial Premium

☐ Draft initial premium upon policy approval ☐ Draft initial premium on the policy effective date

Subsequent draft date****

•

Payment mode

☐ Annually ☐ Quarterly ☐ Semi-annually ☐ Monthly EFT

Initial Premium

☐ Check ☐ EFT ☐ List Bill Billing file identifier:

Section 3. Eligibility Questions

PLEASE ANSWER ALL QUESTIONS. (Please mark yes or no below with an "X".)

If you lost, or are losing, other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

To the best of your knowledge:	**Applicant: A**	**B**
1. Did you turn age 65 in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
i. Did you enroll in Medicare Part B in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
ii. If yes, what is the effective date? *(mm/dd/yyyy)*		

A **Applicant A** effective date

•

B **Applicant B** effective date

•

Section 3. Eligibility Questions *continued*

	Applicant: A	Applicant: B
2. Are you younger than age 65 and eligible for Medicare by reason of disability as defined by federal law?	☐ Yes ☐ No	☐ Yes ☐ No
i. Are you enrolled (or expect to be enrolled) in Medicare Part A and Part B?	☐ Yes ☐ No	☐ Yes ☐ No

ii. If yes, what are the effective dates? *(mm/dd/yyyy)*

A **Applicant A** Part A • Part B •

B **Applicant B** Part A • Part B •

*NOTE: If you are participating in a "Spend-Down Program" and have not met your "share of cost," please **answer no** to question 3.*

3. Are you covered for medical assistance through the state Medicaid program?	☐ Yes ☐ No	☐ Yes ☐ No
i. If yes, will Medicaid pay your premiums for this Medicare Supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No
ii. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	☐ Yes ☐ No	☐ Yes ☐ No
4. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End date" blank.		

A Start date • End date •

B Start date • End date •

i. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No
ii. Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
iii. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
5. Do you have another Medicare Supplement policy in force?	☐ Yes ☐ No	☐ Yes ☐ No

i. If yes, for Applicant A, with what company, and what plan do you have?

A Company • Plan •

If so, for Applicant B, with what company, and what plan do you have?

B Company • Plan •

ii. If so, do you intend to replace your current Medicare Supplement policy with this policy?	☐ Yes ☐ No	☐ Yes ☐ No
iii. Are you replacing another Medicare Supplement policy from The American Home Life Insurance Company?	☐ Yes ☐ No	☐ Yes ☐ No

If yes, list the policy number:

A **Applicant A** •

B **Applicant B** •

6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)	☐ Yes ☐ No	☐ Yes ☐ No

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

A Company • Policy •

B Company • Policy •

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

A Start date • End date •

B Start date • End date •

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

Check if application is for:

Applicant A	☐ Open Enrollment	☐ Guaranteed Issue	☐ Underwritten
Applicant B	☐ Open Enrollment	☐ Guaranteed Issue	☐ Underwritten

Section 4: Health Questions

*Answer these questions **only if you're applying for underwritten coverage**.*
*Do not answer these questions for an **Open Enrollment** or **Guaranteed Issue** application.*

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

Section 4: Health Questions *continued*

*Answer these questions **only if you're applying for underwritten coverage**.*
*Do not answer these questions for an **Open Enrollment** or **Guaranteed Issue** application.*

	Applicant: A	Applicant: B
6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease	☐ Yes ☐ No	☐ Yes ☐ No
B. myasthenia gravis, systemic lupus or connective tissue disorder	☐ Yes ☐ No	☐ Yes ☐ No
C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	☐ Yes ☐ No	☐ Yes ☐ No
D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder	☐ Yes ☐ No	☐ Yes ☐ No
E. any lung or respiratory disorder and currently use tobacco products	☐ Yes ☐ No	☐ Yes ☐ No
7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or surgery that has not been performed or do you have pending test results?	☐ Yes ☐ No	☐ Yes ☐ No
8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?	☐ Yes ☐ No	☐ Yes ☐ No
9. Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving injections?	☐ Yes ☐ No	☐ Yes ☐ No
10. Within the past 12 months, do any of the following apply to you?		
A. had a pacemaker implanted	☐ Yes ☐ No	☐ Yes ☐ No
B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer	☐ Yes ☐ No	☐ Yes ☐ No
C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer	☐ Yes ☐ No	☐ Yes ☐ No
D. had a seizure	☐ Yes ☐ No	☐ Yes ☐ No
11. Was your last blood pressure reading higher than 175 systolic or higher than 100 diastolic?	☐ Yes ☐ No	☐ Yes ☐ No
Systolic is the upper number and diastolic is the bottom number of the blood pressure reading.		
12. Have you used any form of tobacco in the past 12 months? (Including vaping & e-cigarettes)	☐ Yes ☐ No	☐ Yes ☐ No
Answering "yes" to question 12 will not disqualify you for this insurance.		

Applicant A
Height (feet & inches) **Weight** (pounds)

Applicant B
Height (feet & inches) **Weights** (pounds)

Section 5: Health History – Applicant A

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

Applicant A

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

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

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

Section 5: Health History – Applicant B

Applicant B

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

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

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

Use an additional sheet of paper if needed for explanation.

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

Section 6: Physician Information – Applicant A

Applicant A primary physician
•

Phone
•

Physician's office name
•

City
•

State
•

Specialist seen in the past 24 months
•

Specialty
•

Reason for seeing (diagnosis)
•

Specialist seen in the past 24 months
•

Specialty
•

Reason for seeing (diagnosis)
•

Specialist seen in the past 24 months
•

Specialty
•

Reason for seeing (diagnosis)
•

Have you seen any additional physicians other than those listed above in the past 24 months? ☐ Yes ☐ No

Section 6: Physician Information – Applicant B

Applicant B primary physician
•

Phone
•

Physician's office name
•

City
•

State
•

Specialist seen in the past 24 months
•

Specialty
•

Reason for seeing (diagnosis)
•

Specialist seen in the past 24 months
•

Specialty
•

Reason for seeing (diagnosis)
•

Specialist seen in the past 24 months
•

Specialty
•

Reason for seeing (diagnosis)
•

Have you seen any additional physicians other than those listed above in the past 24 months? ☐ Yes ☐ No

Section 7. Important Statements

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

Section 8. Producer Compensation

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

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

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

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

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

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

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

Section 9. Applicant(s) Agreement

This agreement is to acknowledge that I am applying for an insurance policy from The American Home Life Insurance Company that will be issued based on my answers to the questions on this application. I have read, or had read to me, and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are all accurate, complete and correctly documented. I understand that I will receive a copy of the signed application.

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

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

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

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

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

The undersigned applicant and agent certify that the applicant has read, or had read to him, 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.

Under Medicare supplement policies or certificates that use attained age rating, premiums automatically increase as you get older. You can expect your premiums to increase each year (or other frequency as established under the policy or certificate) due to changes in age. The premiums for other Medicare Supplement policies that are issue age or community rated do not increase due to changes in your age.

Currently, the premiums for all ages under this policy are contained in the Outline of Coverage provided by your agent.

While the cost for a Medicare Supplement policy that is based on attained age may be lower than the cost of a Medicare Supplement policy that is issue age or community rated at your present age, it is important to compare the potential cost of these policies over the life of the policy.

☐ **I understand that premium rates will change automatically each year based on my attained age. I acknowledge that I have reviewed the Outline of Coverage provided by my agent.**

☐ I acknowledge that I have received a copy of a Guide to Health Insurance for People with Medicare from my agent.

Applicant A signature	**Date signed**
X	•
Applicant B signature	**Date signed**
X	•
Agent signature	**Date signed**
X	•

Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

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

Section 10. Account Information – Applicant A

Applicant A name

•

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

•

Account Owner relationship to proposed insured

☐ Business owned by proposed insured ☐ Living trust ☐ Employer

☐ Power of Attorney ☐ Conservator/guardian ☐ Family member; please specify:

Financial institution name

•

Account type

☐ Checking ☐ Savings

Routing number

•

Account number

•

Section 10. Account Information – Applicant B

Applicant B name

•

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

•

Account Owner relationship to proposed insured

☐ Business owned by proposed insured ☐ Living trust ☐ Employer

☐ Power of Attorney ☐ Conservator/guardian ☐ Family member; please specify:

Financial institution name

•

Account type

☐ Checking ☐ Savings

Routing number

•

Account number

•

Section 11. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

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

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

Account owner signature – Applicant A

Date signed

X

Account owner signature – Applicant B

Date signed

X

Section 12. Agent Information

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

1. List policies sold which are still in force

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

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

1. List policies sold which are still in force

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

I certify that:

1. I have truly and accurately recorded the information supplied by the applicant(s).
2. I have provided an outline of coverage for the policy(ies) applied for and A Guide to Health Insurance for People with Medicare to applicant(s) prior to completing the application.

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

Agent name *(printed)*	**Agent signature**
•	**X**
Writing number *(agent or company)*	**State license ID number** *(for FL only)*
•	•
Phone	**Email**
•	•

Section 13. Agent request to split commissions

If this application results in an issued policy through The American Home Life Insurance Company (AHLIC), the agents listed below have agreed to split the commissions earned on the policy.

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

Writing agent name *(printed)*		**Percentage**
•		• %
Secondary agent *(printed)*	**Writing number**	**Percentage**
•	•	• %

Writing agent signature

X

This section must be completed with this application in order to split commissions.
By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

The American Home Life Insurance Company
Home Office:
400 S Kansas Ave., Topeka, KS 66601
1-833-504-0334
www.amhlifeco.com

Applicant Receipt

Thank you!

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

Applicant A *(printed)*	**Date of application**
•	•
Initial payment collected *(if applicable)*	**Payment Type**
•	☐ Check ☐ Money order
EFT draft amount	**EFT draft date**
$	•

Applicant B *(printed)*	**Date of application**
•	•
Initial payment collected *(if applicable)*	**Payment Type**
•	☐ Check ☐ Money order
EFT draft amount	**EFT draft date**
$	•

This acknowledges receipt of your application for The American Home Life Insurance Company Medicare Supplement insurance policy.

Agent name *(printed)*	**Agent signature**
•	**X**
Phone	**Email**
•	•

Thank you for choosing The American Home Life Insurance Company!