



THE SALE OF A MEDICARE SUPPLEMENT POLICY IS PROHIBITED WHERE AN INDIVIDUAL HAS A MEDICARE SUPPLEMENT POLICY IN FORCE AND DOES NOT DESIRE TO REPLACE THE EXISTING POLICY OR WHERE THE MEDICARE SUPPLEMENT POLICY WOULD DUPLICATE BENEFITS TO WHICH THE INDIVIDUAL IS ENTITLED UNDER A MEDICARE ADVANTAGE PLAN.

APPLICATION FOR INSURANCE

GLOBE LIFE INSURANCE COMPANY OF NEW YORK \* A NEW YORK STOCK CO. \* HOME OFFICE: SYRACUSE, NY

PART II: ELIGIBILITY QUESTIONS

PLEASE ANSWER ALL QUESTIONS.

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

Yes No

1. (a) Did you turn age 65 in the last six (6) months?  Yes  No

(b) Did you enroll in Medicare Part B in the last six (6) months?  Yes  No

(c) If "YES", what is the effective date? (mm-dd-yyyy)  -  -

2. Are you covered for medical assistance through the state Medicaid program?

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.

Yes  No

If YES,

(a) Will Medicaid pay your premiums for this Medicare Supplement policy?  Yes  No

(b) Do you receive any benefits from Medicaid OTHER THAN payment towards your Medicare Part B premium?  Yes  No

3. (a) If you had coverage from any Medicare Advantage plan other than original Medicare within the past 63 days (for example, a Medicare HMO, PPO or PFFS), fill in your start and end dates below. If you are still covered under the Medicare Advantage plan, leave "END DATE" blank.

START DATE (mm-dd-yyyy)  -  -

END DATE (mm-dd-yyyy)  -  -

Yes No

(b) If you are still covered under the Medicare Advantage 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 Advantage plan?  Yes  No

(d) Did you drop a Medicare Supplement policy to enroll in the Medicare Advantage plan?  Yes  No

4. (a) Do you have another Medicare Supplement or Medicare Select policy in force?  Yes  No

(b) If so, with what company, and what plan do you have? \_\_\_\_\_

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

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

(a) If so, with what company and what kind of policy?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

START DATE (mm-dd-yyyy)  -  -

END DATE (mm-dd-yyyy)  -  -





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**PART IV: AGENT CERTIFICATION**

The undersigned Agent certifies that he/she has  / has not  personally met with the Applicant and that the Applicant has read, or had read to him/her, the completed application.

**AGENT COMPLETES** (Attach separate sheet, if necessary.)

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

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

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I certify: (1) I have accurately recorded the information supplied by the Applicant, (2) I have given an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide to the Applicant, (3) I have reviewed the current health insurance coverage of the Applicant and find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.

Last Name

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Agent No.

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\_\_\_\_\_  
Agent's Signature

**GNYMA15**

MAIL POLICY TO:  Agent  Insured





# Bank Draft Authorization

**Draft date cannot be the 29th, 30th or 31st.**

Proposed Insured's Social Security Number

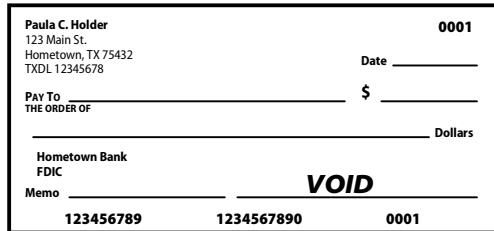
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Requested Bank Draft Day (dd)

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Payor's First Name															M.I.	
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**Account information fields above must be complete if voided check is not attached.**  
See the example check below for the location of the Bank Routing Number and Account Number.



Bank ABA Routing Number: 123456789      Account Number: 1234567890      Check Number: 0001

Helpful Information for Social Security Recipients		
Social Security Benefits Paid On	Birth Date On	Draft Date
Second Wednesday	1 <sup>st</sup> – 10 <sup>th</sup>	14 <sup>th</sup>
Third Wednesday	11 <sup>th</sup> – 20 <sup>th</sup>	21 <sup>st</sup>
Fourth Wednesday	21 <sup>st</sup> – 31 <sup>st</sup>	28 <sup>th</sup>

As a convenience to me, I hereby request and authorize you, Globe Life Insurance Company of New York, Syracuse, New York, to initiate debit entries to my bank account, as recorded above, for insurance premiums and/or non-insurance product fees, as applicable, and the bank named above to debit the same to such account. I agree that your rights and treatment of such debits shall be the same as if they were checks personally signed by me. I further agree that if any such debits are dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance. This authorization will remain in effect until revoked by me in writing to you, provided that you and the bank shall have a reasonable opportunity to act on such notification. All premiums and/or fees may be automatically withdrawn from my account on MONTHLY mode, unless a different mode has been selected on the application(s).

**NOTE - Business accounts are permitted only in relation to sole proprietorships, in which case a voided check and a completed Sole Proprietor form (GNY-SP) are required.**

\_\_\_\_\_  
**Payor's Signature (as it appears on bank records)**

