

Benefit Plans A, C, F, G 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 copayment 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*	G
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
		Skilled Nursing Facility coinsurance	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
		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

K	L	M	N
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
50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-Pocket limit \$4660; paid at 100% after limit reached	Out-of-Pocket limit \$2330; 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 \$2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include Medicare deductibles for Part A and Part B, but do not include the plan’s separate reign travel emergency deductible.

PREMIUM INFORMATION

The premium for your policy will change each year until you are age 99 due to your attained age. This annual change will occur on each policy renewal date that coincides with or follows the policy anniversary date. Schedules of rates may vary depending upon your policy date. Please see the following pages for the premiums for all ages. We, Forethought Life Insurance Company, can also raise your premium if we raise the premium for all the policies like yours in the same geographic area of the state where you live.

NOTE: While the cost of your policy at your present age may be lower than the cost of Medicare Supplement coverage that is based on issue age or community rated, it is important to compare the potential cost of these policies over the life of the coverage. Premiums for other Medicare Supplement policies that are issue age or community rated do not increase due to changes in your age.

There will be a one-time enrollment fee of \$25.00 added to the first premium.

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 Forethought Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Forethought Life Insurance Company, P.O. Box 14659, Clearwater, FL 33766-4659. 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 premiums.

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 Forethought 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. The 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.

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 201, 224 through 231, 233 through 236, 238 through 241, 243 through 245

Standard Plans - Nonsmoker

<i>Female</i>					<i>Attained Age</i>	<i>Male</i>				
<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>		<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>
N/A	N/A	N/A	N/A	N/A	<65	N/A	N/A	N/A	N/A	N/A
81.75	107.17	109.86	86.99	76.85	65	93.96	123.18	126.28	99.99	88.33
81.75	107.17	109.86	86.99	76.85	66	93.96	123.18	126.28	99.99	88.33
81.75	107.17	109.86	86.99	76.85	67	93.96	123.18	126.28	99.99	88.33
84.43	110.70	113.48	89.86	79.39	68	97.05	127.24	130.44	103.29	91.25
87.03	114.34	117.22	92.84	82.04	69	100.04	131.42	134.73	106.71	94.30
89.51	117.88	120.83	95.73	84.63	70	102.88	135.49	138.89	110.04	97.28
91.85	121.28	124.32	98.53	87.15	71	105.58	139.40	142.90	113.25	100.17
94.07	124.56	127.68	101.22	89.58	72	108.13	143.17	146.76	116.35	102.96
96.06	127.56	130.76	103.70	91.81	73	110.41	146.62	150.30	119.19	105.53
97.79	130.34	133.61	106.00	93.91	74	112.40	149.82	153.58	121.84	107.94
100.25	134.16	137.53	109.16	96.78	75	115.23	154.21	158.08	125.47	111.24
103.66	139.33	142.82	113.41	100.62	76	119.15	160.15	164.16	130.36	115.66
105.00	141.72	145.27	115.41	102.48	77	120.69	162.90	166.98	132.66	117.79
107.28	145.38	149.01	118.44	105.24	78	123.31	167.10	171.28	136.14	120.96
108.46	147.58	151.27	120.29	106.96	79	124.66	169.63	173.87	138.27	122.94
109.64	149.80	153.54	122.15	108.68	80	126.02	172.18	176.48	140.40	124.92
110.73	151.95	155.74	123.97	110.37	81	127.28	174.65	179.01	142.49	126.86
112.83	155.51	159.38	126.93	113.10	82	129.69	178.75	183.20	145.90	130.00
113.75	157.48	161.40	128.60	114.67	83	130.75	181.01	185.52	147.82	131.80
114.60	159.41	163.38	130.24	116.22	84	131.72	183.23	187.79	149.70	133.59
116.50	162.81	166.87	133.08	118.85	85	133.91	187.14	191.80	152.97	136.61
117.28	164.70	168.79	134.69	120.38	86	134.80	189.31	194.01	154.82	138.37
118.08	166.65	170.79	136.36	121.97	87	135.72	191.55	196.31	156.74	140.19
118.87	168.56	172.76	137.99	123.51	88	136.63	193.75	198.56	158.61	141.97
119.68	170.53	174.76	139.67	125.11	89	137.56	196.01	200.87	160.54	143.81
121.63	174.16	178.47	142.76	127.98	90	139.81	200.18	205.14	164.09	147.10
122.48	176.19	180.56	144.54	129.68	91	140.78	202.52	207.54	166.14	149.06
123.36	178.32	182.73	146.40	131.45	92	141.79	204.96	210.03	168.28	151.09
124.25	180.49	184.94	148.31	133.27	93	142.82	207.46	212.58	170.47	153.18
125.18	182.77	187.28	150.32	135.18	94	143.89	210.08	215.27	172.78	155.38
127.28	186.80	191.41	153.76	138.38	95	146.30	214.71	220.01	176.73	159.06
128.16	189.09	193.75	155.77	140.31	96	147.31	217.35	222.70	179.05	161.28
128.97	191.29	195.99	157.71	142.18	97	148.24	219.87	225.28	181.28	163.42
129.75	193.51	198.27	159.68	144.06	98	149.14	222.42	227.90	183.54	165.59
130.55	195.79	200.61	161.70	146.01	99	150.06	225.05	230.59	185.86	167.83

* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 201, 224 through 231, 233 through 236, 238 through 241, 243 through 245

Standard Plans - Smoker

<i>Female</i>					<i>Attained Age</i>	<i>Male</i>				
<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>		<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>
N/A	N/A	N/A	N/A	N/A	<65	N/A	N/A	N/A	N/A	N/A
93.96	123.18	126.28	99.99	88.33	65	108.00	141.58	145.15	114.93	101.53
93.96	123.18	126.28	99.99	88.33	66	108.00	141.58	145.15	114.93	101.53
93.96	123.18	126.28	99.99	88.33	67	108.00	141.58	145.15	114.93	101.53
97.05	127.24	130.44	103.29	91.25	68	111.55	146.25	149.93	118.72	104.88
100.04	131.42	134.73	106.71	94.30	69	114.98	151.06	154.86	122.65	108.39
102.88	135.49	138.89	110.04	97.28	70	118.26	155.73	159.65	126.48	111.82
105.58	139.40	142.90	113.25	100.17	71	121.35	160.23	164.26	130.17	115.14
108.13	143.17	146.76	116.35	102.96	72	124.28	164.56	168.69	133.73	118.34
110.41	146.62	150.30	119.19	105.53	73	126.91	168.53	172.76	137.00	121.30
112.40	149.82	153.58	121.84	107.94	74	129.20	172.20	176.52	140.04	124.07
115.23	154.21	158.08	125.47	111.24	75	132.45	177.26	181.70	144.22	127.87
119.15	160.15	164.16	130.36	115.66	76	136.96	184.08	188.69	149.84	132.95
120.69	162.90	166.98	132.66	117.79	77	138.73	187.24	191.93	152.49	135.39
123.31	167.10	171.28	136.14	120.96	78	141.74	192.07	196.87	156.49	139.04
124.66	169.63	173.87	138.27	122.94	79	143.29	194.98	199.85	158.93	141.31
126.02	172.18	176.48	140.40	124.92	80	144.85	197.90	202.85	161.38	143.59
127.28	174.65	179.01	142.49	126.86	81	146.30	200.75	205.76	163.78	145.82
129.69	178.75	183.20	145.90	130.00	82	149.06	205.46	210.58	167.70	149.42
130.75	181.01	185.52	147.82	131.80	83	150.29	208.06	213.25	169.90	151.50
131.72	183.23	187.79	149.70	133.59	84	151.41	210.61	215.85	172.07	153.55
133.91	187.14	191.80	152.97	136.61	85	153.92	215.11	220.46	175.83	157.02
134.80	189.31	194.01	154.82	138.37	86	154.95	217.60	223.00	177.96	159.04
135.72	191.55	196.31	156.74	140.19	87	156.00	220.18	225.64	180.16	161.14
136.63	193.75	198.56	158.61	141.97	88	157.05	222.70	228.23	182.32	163.19
137.56	196.01	200.87	160.54	143.81	89	158.11	225.30	230.89	184.53	165.30
139.81	200.18	205.14	164.09	147.10	90	160.70	230.10	235.80	188.61	169.08
140.78	202.52	207.54	166.14	149.06	91	161.82	232.79	238.55	190.97	171.33
141.79	204.96	210.03	168.28	151.09	92	162.98	235.58	241.41	193.43	173.67
142.82	207.46	212.58	170.47	153.18	93	164.16	238.45	244.35	195.95	176.07
143.89	210.08	215.27	172.78	155.37	94	165.39	241.47	247.43	198.59	178.59
146.30	214.71	220.01	176.73	159.06	95	168.16	246.79	252.88	203.14	182.83
147.31	217.35	222.70	179.05	161.28	96	169.33	249.82	255.98	205.81	185.38
148.24	219.87	225.28	181.28	163.42	97	170.39	252.72	258.94	208.36	187.83
149.14	222.42	227.90	183.54	165.59	98	171.43	255.66	261.95	210.96	190.34
150.06	225.05	230.59	185.86	167.83	99	172.48	258.68	265.04	213.64	192.91

* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 220 through 223, 232, 237, 242, 246

Standard Plans - Nonsmoker

<i>Female</i>					<i>Attained Age</i>	<i>Male</i>				
<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>		<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>
N/A	N/A	N/A	N/A	N/A	<65	N/A	N/A	N/A	N/A	N/A
91.56	120.03	123.04	97.43	86.07	65	105.24	137.96	141.43	111.99	98.93
91.56	120.03	123.04	97.43	86.07	66	105.24	137.96	141.43	111.99	98.93
91.56	120.03	123.04	97.43	86.07	67	105.24	137.96	141.43	111.99	98.93
94.56	123.98	127.10	100.64	88.92	68	108.70	142.51	146.09	115.68	102.20
97.47	128.06	131.29	103.98	91.88	69	112.04	147.19	150.90	119.52	105.62
100.25	132.03	135.33	107.22	94.79	70	115.23	151.75	155.56	123.24	108.95
102.87	135.83	139.24	110.35	97.61	71	118.25	156.13	160.05	126.84	112.19
105.36	139.51	143.00	113.37	100.33	72	121.11	160.35	164.37	130.31	115.32
107.59	142.87	146.45	116.14	102.83	73	123.66	164.21	168.34	133.49	118.19
109.52	145.98	149.64	118.72	105.18	74	125.89	167.80	172.01	136.46	120.89
112.28	150.26	154.03	122.26	108.39	75	129.06	172.72	177.05	140.53	124.59
116.10	156.05	159.96	127.02	112.69	76	133.45	179.37	183.86	146.00	129.54
117.60	158.73	162.70	129.26	114.78	77	135.17	182.45	187.02	148.58	131.92
120.15	162.83	166.89	132.65	117.87	78	138.11	187.15	191.83	152.48	135.48
121.48	165.29	169.42	134.72	119.80	79	139.62	189.99	194.73	154.86	137.69
122.80	167.78	171.96	136.81	121.72	80	141.14	192.84	197.66	157.25	139.91
124.02	170.18	174.43	138.85	123.61	81	142.55	195.61	200.49	159.59	142.08
126.37	174.17	178.51	142.16	126.67	82	145.25	200.20	205.18	163.41	145.60
127.40	176.38	180.77	144.03	128.43	83	146.44	202.73	207.78	165.56	147.62
128.35	178.54	182.99	145.87	130.17	84	147.53	205.22	210.32	167.66	149.62
130.48	182.35	186.89	149.05	133.11	85	149.98	209.60	214.82	171.33	153.00
131.35	184.46	189.04	150.85	134.83	86	150.98	212.03	217.29	173.40	154.97
132.25	186.65	191.28	152.72	136.61	87	152.01	214.54	219.87	175.55	157.01
133.13	188.79	193.49	154.55	138.33	88	153.03	217.00	222.39	177.64	159.01
134.04	190.99	195.73	156.43	140.12	89	154.07	219.53	224.97	179.80	161.07
136.23	195.06	199.89	159.89	143.34	90	156.59	224.20	229.76	183.78	164.75
137.18	197.33	202.23	161.88	145.24	91	157.67	226.82	232.44	186.08	166.95
138.16	199.72	204.66	163.97	147.22	92	158.80	229.56	235.23	188.47	169.22
139.16	202.15	207.13	166.11	149.26	93	159.96	232.36	238.09	190.93	171.56
140.20	204.70	209.75	168.36	151.40	94	161.16	235.29	241.10	193.51	174.03
142.55	209.22	214.38	172.21	154.99	95	163.86	240.48	246.41	197.94	178.15
143.54	211.78	217.00	174.46	157.15	96	164.99	243.43	249.42	200.54	180.63
144.45	214.24	219.51	176.64	159.24	97	166.03	246.25	252.31	203.03	183.03
145.32	216.73	222.06	178.84	161.35	98	167.04	249.11	255.25	205.56	185.46
146.22	219.28	224.68	181.10	163.53	99	168.07	252.06	258.26	208.16	187.97

* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively

FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates *

These rates apply to ZIP codes starting with: 220 through 223, 232, 237, 242, 246

Standard Plans - Smoker

<i>Female</i>					<i>Attained Age</i>	<i>Male</i>				
<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>		<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>
N/A	N/A	N/A	N/A	N/A	<65	N/A	N/A	N/A	N/A	N/A
105.24	137.96	141.43	111.99	98.93	65	120.96	158.57	162.57	128.72	113.71
105.24	137.96	141.43	111.99	98.93	66	120.96	158.57	162.57	128.72	113.71
105.24	137.96	141.43	111.99	98.93	67	120.96	158.57	162.57	128.72	113.71
108.70	142.51	146.09	115.68	102.20	68	124.94	163.80	167.92	132.97	117.47
112.04	147.19	150.90	119.52	105.62	69	128.78	169.19	173.44	137.37	121.40
115.23	151.75	155.56	123.24	108.95	70	132.45	174.42	178.81	141.66	125.24
118.25	156.13	160.05	126.84	112.19	71	135.91	179.46	183.97	145.79	128.96
121.11	160.35	164.37	130.31	115.32	72	139.19	184.31	188.93	149.78	132.54
123.66	164.21	168.34	133.49	118.19	73	142.14	188.75	193.49	153.44	135.86
125.89	167.80	172.01	136.46	120.89	74	144.70	192.86	197.70	156.84	138.96
129.06	172.72	177.05	140.53	124.59	75	148.34	198.53	203.50	161.53	143.21
133.45	179.37	183.86	146.00	129.54	76	153.40	206.17	211.33	167.82	148.90
135.17	182.45	187.02	148.58	131.92	77	155.38	209.71	214.96	170.79	151.64
138.11	187.15	191.83	152.48	135.48	78	158.75	215.12	220.49	175.27	155.72
139.62	189.99	194.73	154.86	137.69	79	160.48	218.38	223.83	178.00	158.27
141.14	192.84	197.66	157.25	139.91	80	162.23	221.65	227.19	180.75	160.82
142.55	195.61	200.49	159.59	142.08	81	163.86	224.84	230.45	183.43	163.32
145.25	200.20	205.18	163.41	145.60	82	166.95	230.12	235.85	187.82	167.35
146.44	202.73	207.78	165.56	147.62	83	168.32	233.03	238.84	190.29	169.68
147.53	205.22	210.32	167.66	149.62	84	169.58	235.88	241.75	192.72	171.98
149.98	209.60	214.82	171.33	153.00	85	172.39	240.92	246.92	196.93	175.86
150.98	212.03	217.29	173.40	154.97	86	173.54	243.71	249.76	199.32	178.12
152.01	214.54	219.87	175.55	157.01	87	174.72	246.60	252.72	201.78	180.48
153.03	217.00	222.39	177.64	159.01	88	175.90	249.42	255.62	204.20	182.77
154.07	219.53	224.97	179.80	161.07	89	177.08	252.34	258.60	206.67	185.14
156.59	224.20	229.76	183.78	164.75	90	179.98	257.71	264.10	211.24	189.37
157.67	226.82	232.44	186.08	166.95	91	181.24	260.72	267.18	213.89	191.89
158.80	229.56	235.23	188.47	169.22	92	182.54	263.85	270.38	216.64	194.51
159.96	232.36	238.09	190.93	171.56	93	183.86	267.06	273.67	219.46	197.20
161.16	235.29	241.10	193.51	174.01	94	185.24	270.45	277.12	222.42	200.02
163.86	240.48	246.41	197.94	178.15	95	188.34	276.40	283.23	227.52	204.77
164.99	243.43	249.42	200.54	180.63	96	189.65	279.80	286.70	230.51	207.63
166.03	246.25	252.31	203.03	183.03	97	190.84	283.05	290.01	233.36	210.37
167.04	249.11	255.25	205.56	185.46	98	192.00	286.34	293.38	236.28	213.18
168.07	252.06	258.26	208.16	187.97	99	193.18	289.72	296.84	239.28	216.06

* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively

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 61 st thru 90 th day 91 st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> - Additional 365 days - Beyond the additional 365 days 	All but \$1,156 All but \$289 a day All but \$578 a day \$0 \$0	\$0 \$289 a day \$578 a day 100% of Medicare Eligible Expenses \$0	\$1,156 (Part A Deductible) \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$144.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$144.50 a day All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 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 \$140 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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$140 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$140 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES • Medically necessary skilled care services and medical supplies • Durable medical equipment	100%	\$0	\$0
- First \$140 of Medicare-approved amounts* - Remainder of Medicare-approved amounts	\$0 80%	\$0 20%	\$140 (Part B Deductible) \$0

PLAN C
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 61 st thru 90 th day 91 st day and after: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1,156 All but \$289 a day All but \$578 a day \$0 \$0	\$1,156 (Part A Deductible) \$289 a day \$578 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 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 C
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once You have been billed \$140 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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$140 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$140 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$140 (Part B Deductible) 20%	\$0 \$0 \$0
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OTHER BENEFITS – NOT COVERED BY MEDICARE

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
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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 61 st thru 90 th day 91 st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> - Additional 365 days - Beyond the additional 365 days 	All but \$1,156 All but \$289 a day All but \$578 a day \$0 \$0	\$1,156 (Part A Deductible) \$289 a day \$578 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 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 \$140 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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$140 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$140 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment <ul style="list-style-type: none"> - First \$140 of Medicare-approved amounts* - Remainder of Medicare-approved amounts 	100% \$0 80%	\$0 \$140 (Part B Deductible) 20%	\$0 \$0 \$0
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OTHER BENEFITS – NOT COVERED BY MEDICARE

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
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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 61 st thru 90 th day 91 st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> - Additional 365 days - Beyond the additional 365 days 	All but \$1,156 All but \$289 a day All but \$578 a day \$0 \$0	\$1,156 (Part A Deductible) \$289 a day \$578 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 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 \$140 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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$140 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$140 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$140 (Part B Deductible) \$0
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OTHER BENEFITS – NOT COVERED BY MEDICARE

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
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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 61 st thru 90 th day 91 st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> - Additional 365 days - Beyond the additional 365 days 	All but \$1,156 All but \$289 a day All but \$578 a day \$0 \$0	\$1,156 (Part A Deductible) \$289 a day \$578 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 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 \$140 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 OUT-PATIENT 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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment 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.	\$140 (Part B Deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment 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 Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$140 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN N

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment			
- First \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (Part B Deductible)
- Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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Agent checklist for completing the Medicare Supplement / Life Insurance Application

FORE THOUGHT[®]

This packet contains the following forms needed to complete an Application For Medicare Supplement Insurance and Life Insurance. Please tear out the **application** and all pages marked “**RETURN TO COMPANY**” and leave the remaining pages with the applicant(s). Please review the following information carefully and complete all needed forms:

- Application For Medicare Supplement Insurance and Life Insurance (Form MSAP1000-01 or MSAPC1000-01)
 - Medicare Supplement – If the applicant(s) is applying during Open Enrollment or a Guaranteed Issue period, Section 4 is not required to be completed
 - Life Insurance – Section 4 is required when the applicant(s) is applying for life insurance
 - Section 5 should be completed only if the applicant(s) would like his/her payments to be deducted automatically from his/her checking/savings account. This option applies only if premiums are paid monthly
- Agent Certification (Form AGTCRT10-01) – This form must be signed by the agent and by the applicant(s).
- Calculate your premium – This form is used to calculate the correct life insurance premium and, in coordination with the Outline of Coverage, to calculate the correct Medicare Supplement premium. This form must be returned with the application.
- Fax Transmittal – Follow the instructions on this form only if the applicant(s) elects to pay premiums using ACH and you are submitting the underwriting documents via fax instead of regular mail.
- Authorization to Release Confidential Medical Information (Form MS-HIPAA10-01-VA) – Must be completed **only** if applying outside Open Enrollment or a Guaranteed Issue period for Medicare Supplement **or** if applying for life insurance. If both spouses are applying for coverage on the same application, then both must sign the form.
- Notice to Applicant regarding replacement of Medicare Supplement Insurance or Medicare Advantage (Form MS-RN10-01) – This form must be completed if replacement of an existing Medicare Supplement policy is involved. One signed copy must be returned to the Administrative Office and the other signed copy must be left with the applicant(s).
- Notice for Replacement of Life Insurance or Annuities (A7012-03-VA) – This form must be completed if replacement of existing life insurance is involved. One signed copy must be returned to the Administrative Office and the other signed copy must be left with the applicant(s).
- Investigative Consumer Report Notice to Applicant, Medical Information Bureau Disclosure Notice, Medicare Supplement/ Select Initial Premium Receipt, and Life Insurance Conditional Coverage receipt (MSREC-01) – The Initial/Conditional Premium Receipts must be left with the applicant(s) and the full modal premium is required with all applications.

Please note, you are also required to provide the applicant(s) with the following items:

- Guide to Health Insurance for People with Medicare
- Outline of Coverage (Form MSOC10-01)

Premiums and policy fee

Utilize the Freedom[®] FreedomSM final expense premium chart to determine the correct monthly life insurance premium. Utilize the Outline of Coverage to determine Medicare Supplement premiums.

- Determine ZIP code where the client resides and find the correct rate page for that ZIP code
- Determine Plan
- Determine if tobacco or non-tobacco use
- Find age/gender – Verify that the age and date of birth are the exact age as of the application date, this will be your base monthly premium
- Use the Calculate your premium form to adjust the monthly premium for different modes and to add the policy fee
- A voided check needs to be submitted with the Application for EFT

There will be a one-time Medicare Supplement application fee of \$25.00 that must be collected with each applicant's initial payment. If both spouses are written on the same application, \$50.00 in fees must be collected. This will not affect the renewal premiums.

Mailing Address

Forethought Life Insurance Company
Administrative office
P.O. Box 14659
Clearwater, FL 33766-4659

Overnight/Express Address

Forethought Life Insurance Company
Administrative office
2650 McCormick Drive
Clearwater, FL 33759

FAX Number for New Business - EFT Applications 1-855-808-0944

Forethought Life Insurance Company
One Forethought Center
Batesville, Indiana 47006

Administrative Office:
P. O. Box 14659
Clearwater, FL 33766-4659

MEDICARE SUPPLEMENT PLAN INFORMATION (To be completed by Producer)

NOTE: For ALL sections, complete the Applicant B information ONLY if Applicant B is to be insured.

APPLICANT	
Medicare Supplement Standard Plan	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> N
Medicare Supplement Select Plan (not available in all states)	<input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> N
Requested Effective Date / /	Mail Policy To <input type="checkbox"/> Insured <input type="checkbox"/> Agent
Initial Premium Collected \$	Renewal Premium \$
Renewal Premium Mode <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly EFT	
APPLICANT B	
Medicare Supplement Standard Plan	<input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> N
[Medicare Supplement Select Plan (not available in all states)]	[<input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> N]
Requested Effective Date / /	Mail Policy To <input type="checkbox"/> Insured <input type="checkbox"/> Agent
Initial Premium Collected \$	Renewal Premium \$
Renewal Premium Mode <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly EFT	

SECTION 1 - IF APPLYING FOR MEDICARE SUPPLEMENT INSURANCE AND/OR LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS COMPLETELY.

APPLICANT					
Last Name	First		M.I.		
Mailing Address					
Residential Address (if different from Mailing Address)					
City	State		Zip		
Age	Date of Birth	State of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Home Phone # () - -	E-Mail Address		Height Weight		
Social Security Number	Height		Weight		
Medicare Health Insurance Card Number (if known)					
Have you used tobacco in any form in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
APPLICANT B					
Last Name	First		M.I.		
Mailing Address					
Residential Address (if different from Mailing Address)					
City	State		Zip		
Age	Date of Birth	State of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Home Phone # () - -	E-Mail Address		Height Weight		
Social Security Number	Height		Weight		
Medicare Health Insurance Card Number (if known)					

SECTION 2 - IF APPLYING FOR MEDICARE SUPPLEMENT INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

1. Have you received a copy of the Guide to Health Insurance for People with Medicare and the Outline of Coverage?	APPLICANT <input type="checkbox"/> Yes <input type="checkbox"/> No	APPLICANT B <input type="checkbox"/> Yes <input type="checkbox"/> No
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A: If "YES," what is your Part A effective date? _____ / _____ / _____ Applicant _____ / _____ / _____ Applicant B _____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "NO," what is your eligibility date? _____ / _____ / _____ Applicant _____ / _____ / _____ Applicant B _____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you covered under Medicare Part B? If "YES," what is your Part B effective date? _____ / _____ / _____ Applicant _____ / _____ / _____ Applicant B _____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "NO," indicate date you plan to enroll. Applicant _____ / _____ / _____ Applicant B _____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did you turn age 65 in the last six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Did you enroll in Medicare Part B in the last six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. If "YES," indicate your effective date. _____ / _____ / _____ Applicant _____ / _____ / _____ Applicant B _____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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 certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed accepted in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.** Please mark "YES" or "NO" with an "X" to the questions below.

SECTION 3 - FOR YOUR PROTECTION WE ASK THE FOLLOWING QUESTIONS ABOUT INSURANCE POLICIES OR CERTIFICATES YOU MAY HAVE.

To the Best of Your Knowledge:	APPLICANT	APPLICANT B
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have another Medicare Supplement Insurance policy or certificate in force (Select or Standard)? (a) If "YES," please complete the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICANT		
Name of Company	Policy/Certificate Number	Issue Date
Plan	_____ / _____	_____ / _____
APPLICANT B		
Name of Company	Policy/Certificate Number	Issue Date
Plan	_____ / _____	_____ / _____
(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) If "YES," indicate termination date. _____ / _____ / _____ Applicant _____ / _____ / _____ Applicant B _____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If "YES," have you received a copy of the replacement notice?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.		
3. 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" blank. START _____ / _____ / _____ START _____ / _____ / _____ Applicant _____ / _____ / _____ Applicant B _____ / _____ / _____		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(b) If "YES," have you received a copy of the replacement notice?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Reason for termination/disenrollment? _____ Applicant	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Planned date of termination/disenrollment? _____/_____/_____ Applicant	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) Was this your first time in this type of Medicare plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(f) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(g) Is your former Medicare supplement or Medicare Select policy/certificate still available?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICANT

Name of Company	Kind of Policy/Certificate
-----------------	----------------------------

APPLICANT B

Name of Company	Kind of Policy/Certificate
-----------------	----------------------------

(b) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank. START ____/____/____ END ____/____/____	Applicant	Applicant B
(c) Reason for termination/disenrollment? _____ Applicant	Applicant	Applicant B
(d) Planned date of termination/disenrollment? _____/_____/_____ Applicant	Applicant	Applicant B

5. 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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "YES,"		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 4

IF APPLYING FOR ONLY MEDICARE SUPPLEMENT INSURANCE:

- During Open Enrollment or a Guaranteed Issue period, SKIP SECTION 4 and GO TO SECTION 5.
- NOT during Open Enrollment or a Guaranteed Issue period, PLEASE ANSWER ALL QUESTIONS.

IF APPLYING FOR LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS.

To the Best of Your Knowledge:		APPLICANT	APPLICANT B
1.	Have you used tobacco in any form in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Are you currently hospitalized or confined to a nursing facility; or are you bedridden or confined to a wheelchair?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	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".	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Do you have diabetes that has ever required more than 50 units of insulin daily?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Have you been hospitalized three or more times in the last two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Have you had an organ transplant or been advised by a physician to have an organ transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	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 and the condition in the following table.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICANT (attach a separate sheet if needed)	
Medication Name (pharmacy label)	Date Originally Prescribed / /
Frequency and Dosage	Diagnosis/Condition
APPLICANT B (attach a separate sheet if needed)	
Medication Name (pharmacy label)	Date Originally Prescribed / /
Frequency and Dosage	Diagnosis/Condition

SECTION 5 - IF APPLYING FOR LIFE INSURANCE, PLEASE COMPLETE ALL QUESTIONS

NOTE: If you are in Open Enrollment or eligible for Guaranteed Issue for a Medicare Supplement policy and are applying for Life Insurance, you **MUST** answer all the questions in SECTION 4 of the application.

APPLICANT			
Beneficiary Name	Relationship To Applicant	Face Amount: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <input type="checkbox"/> Other _____	
Life Insurance Premium remitted with application	Premium Mode:	Automatic Premium Loan - <i>if available</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
\$	<input type="checkbox"/> Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Monthly EFT		
APPLICANT B (if applying for coverage)			
Beneficiary Name	Relationship To Applicant	Face Amount: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <input type="checkbox"/> Other _____	
Life Insurance Premium remitted with application	Premium Mode:	Automatic Premium Loan - <i>if available</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
\$	<input type="checkbox"/> Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Monthly EFT		

SECTION 6 - REPLACEMENT

1. Are there any existing life insurance policies/annuity contracts on the life of the applicant? NOTE: If "YES," complete the appropriate Forethought Replacement form for the state where the applicant resides and submit with the application form.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is this life insurance intended to replace or change any existing life insurance policy or annuity?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 7 - BILLING INFORMATION

A. ELECTRONIC FUNDS TRANSFER (EFT)

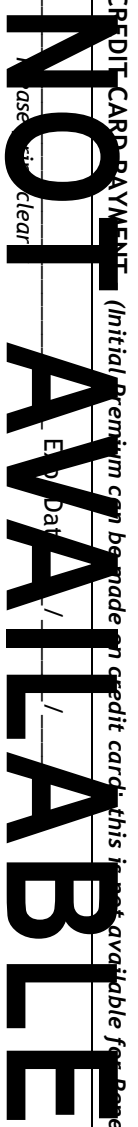
<input type="checkbox"/> Checking	Account #
<input type="checkbox"/> Savings	ABA Routing/Transit Number
<input type="checkbox"/> Standard Date (approximately 30 days from the issue date of coverage) <input type="checkbox"/> Custom Date ____/____/____ (Select 1-28)	

When processing is not complete prior to the custom date selected, two (2) premium payments may be withdrawn the following month to keep your policy current.. To prevent this from happening, you may prefer to include an additional premium payment.

Name and Telephone Number of Financial Institution	Social Security Number of Account Holder
--	--

B. INITIAL CREDIT CARD PAYMENT (Initial Premium can be made on credit card; this is not available for Renewal Premiums)

Account # _____
 Cardholder Name _____
 Cardholder Name _____



C. AUTOMATIC PAYMENT AUTHORIZATION - (Must be completed for EFT)

I authorize Forethought Life Insurance Company ("Forethought") to charge/deduct my insurance premium from my account. This authorization is to remain in effect until I revoke my automatic monthly premium payment by notifying Forethought.

Payor's Signature (As it appears on the bank account)	Date
_____	____/____/____

SECTION 8 - SIGNATURES - PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT IF PURCHASING MEDICARE SUPPLEMENT INSURANCE COVERAGE

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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).

I understand that Forethought may obtain an investigative consumer report on me and a telephone interview may be necessary to verify or supplement information given on this application. I understand that it is my right to request to be interviewed and that I may request a copy of the report. A photocopy of this form will be as valid as the original. I understand that no agent has the right to waive any of Forethought's rights or requirements, or to make or alter any contract or policy. I agree that my statements and answers to the questions in this application are complete and true to the best of my knowledge and belief and are the basis for issuing a policy.

By this application I am applying to Forethought for:

- A Medicare supplement insurance policy. I understand that, (a) upon acceptance of the completed application, each applicant will receive a separate policy; (b) my policy benefits can start no earlier than my Medicare effective date(s), my first month's premium has been received and/or processed and my application has been approved by Forethought.
- A Life insurance policy. I understand that, (a) no insurance will take effect until the premium has been paid and a policy has been issued while the insured is living, the first premium has been paid, and my insurability as stated in this application remains unchanged; (b) acceptance of the life insurance policy issued on this application shall constitute agreement to any correction or amendment of this application made by Forethought and noted on this application; (c) no change in amount, age at issue, plan of insurance or benefit applied for shall be made unless agreed to in writing by me; and (d) during the contestable period, Forethought has the right to rescind any life insurance policy issued upon statements or answers in this application that are not correct.

Any person who, with the 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 may have violated the state law.

Signed this _____ day of _____, _____ in _____, _____ State _____, _____
Day Month Year City State APPLICANT SIGNATURE

Signed this _____ day of _____, _____ in _____, _____ State _____, _____
Day Month Year City State APPLICANT B SIGNATURE (if applicable)

TO BE SIGNED BY APPLICANT(S) AND AGENT

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.

Applicant Signature _____ Date _____ Applicant B Signature (if applicable) _____ Date _____
 Agent Signature _____ Date _____

AGENT ONLY SECTION - PREMIUM MUST ACCOMPANY APPLICATION

I certify that during an interview with the applicant(s) I have truly and accurately recorded in the application the information supplied by the applicant(s).

Are there any existing life insurance policies/annuity contracts on the life of the applicant? Yes No
 Do you have any knowledge or reason to believe that this application replaced existing life insurance? Yes No

Producer's Name (PRINT) _____ Producer Number _____ Telephone Number _____ Producer's Signature _____

Producers shall list below any other health insurance policies/certificates they have sold to the applicant.
 List policies/certificates sold which are still in force.

APPLICANT (attach a separate sheet if needed)			
Name of Company	Policy/Certificate #		
Description of Benefits	Effective Date of Coverage	/	/
List policies/certificates sold in the past five (5) years which are no longer in force:			
Name of Company	Policy/Certificate #		
Description of Benefits	Effective Date of Coverage	/	/
APPLICANT B (attach a separate sheet if needed)			
Name of Company	Policy/Certificate #		
Description of Benefits	Effective Date of Coverage	/	/
List policies/certificates sold in the past five (5) years which are no longer in force:			
Name of Company	Policy/Certificate #		
Description of Benefits	Effective Date of Coverage	/	/

SECTION FOR ADDITIONAL COMMENTS

APPLICANT - (please attach a separate sheet if needed)			

APPLICANT B - (please attach a separate sheet if needed)

Agent Certification

FORETHOUGHT LIFE INSURANCE COMPANY
Administrative Office P.O. Box 14659, Clearwater, FL 33766-4659 1-877-492-5870



I the undersigned insurance agent certify;

THAT, I have taken an application for:

Primary insured:		Applicant B:	
Medicare Supplement Standard	Medicare Supplement Select	Medicare Supplement Standard	Medicare Supplement Select
<input type="checkbox"/> Plan A	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan A	<input type="checkbox"/> Plan C
<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan F	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan F
<input type="checkbox"/> Plan F	<input type="checkbox"/> Plan G	<input type="checkbox"/> Plan F	<input type="checkbox"/> Plan G
<input type="checkbox"/> Plan G	<input type="checkbox"/> Plan N	<input type="checkbox"/> Plan G	<input type="checkbox"/> Plan N
<input type="checkbox"/> Plan N		<input type="checkbox"/> Plan N	<input type="checkbox"/> Plan N

Offered by FORETHOUGHT LIFE INSURANCE COMPANY,

to _____
(Applicant(s)),

THAT, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of

\$ _____ which has been paid to me by

Check ~~Money order~~ NOT AVAILABLE ACH (Check appropriate method of payment)

THAT, I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services in connection with this insurance policy being applied for.

Date _____ Signature of agent _____

I, the undersigned applicant, understand that I will receive a copy of this form when my policy is issued and delivered to me. Name of agency _____

Signature of applicant _____ Address of agent / Agency _____

Signature of spouse, if applying _____ Phone number _____

Forethought Life Insurance Company
PO Box 14659
Clearwater, FL 33766-4659

Authorization to Release Confidential Medical Information

Records and information obtained will be disclosed to Forethought Life Insurance Company so that it can: 1) evaluate my application for insurance; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) and administer coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, the MIB, Inc., the Veterans Administration or other insurance companies to release any and all medical records to be exchanged between Forethought Life Insurance Company and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and it assigns as necessary to fulfill the purpose of this disclosure.

I hereby authorize you to release any and all records within your possession, custody or control regarding me pursuant to this Authorization. Any and all medical records regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, testing, treatment, or advice for the following: alcohol abuse, drug abuse, psychiatric and psychological disorders, heart disease, mental disease, genetic disorders, pharmacy prescriptions, HIV or AIDS, sexually transmitted diseases, hepatitis, and Sickle Cell Anemia.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. I understand Forethought Life Insurance Company may report information to MIB, Inc. or to other insurance companies to which I have or may apply. I understand this Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Forethought Life Insurance Company at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. I understand a photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Forethought Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

Name of Proposed Insured (please print)

Name of Proposed Insured B (please print)

Signature of Proposed Insured

Signature of Proposed Insured B

Date

Date

RETURN TO COMPANY

Forethought® FreedomSM Final Expense Life Insurance



Forethought® FreedomSM is a whole life insurance product designed to help cover final expenses such as the costs associated with funeral and burial expenses. The Forethought Freedom product provides guaranteed, level premiums and uses the same simplified application as the Forethought® Medicare Supplement Standard and Select Plans.

- Minimum face amount – \$2,500
- Maximum face amount – \$25,000 Level death benefit
\$15,000 Graded death benefit
\$10,000 Return of premium death benefit
- Policy is rated on age at last birthday – may backdate 6 months to save age.
- Monthly bank draft premiums are displayed on the rate chart.
 - Other modal premiums available are quarterly, semi-annual and annual.
See rate chart for modal factors.
- Underwriting Classes are Smoker and Non-Smoker.
 - A smoker is considered anyone who has smoked cigarettes in the past 12 months.
- One check for both a Medicare Supplement policy and a Forethought Freedom policy is acceptable.
- The Calculate your premium form must be completed and submitted with application.

Death benefit	Months 1-12	Months 13-24	Months 25+
Level benefit	100% of face	100% of face	100% of face
Graded benefit* (Accidental Death - 100% of face)	30% of face	70% of face	100% of face
Return of premium benefit*	110% premiums paid	110% premiums paid	100% of face

* Not available in all states.

Please advise your client that a phone interview will be conducted within the next few days so they will be prepared to receive the call.

This is only a brief description of the policy guidelines. Please refer additional questions to your licensed insurance agent.

Monthly EFT premium rates – full death benefit coverage only

Issue Age	Female									
	Per \$1,000		\$2,500		\$5,000		\$7,500		\$10,000	
	NS	S	NS	S	NS	S	NS	S	NS	S
65	\$3.89	\$5.54	\$13.10	\$17.21	\$22.84	\$31.05	\$32.57	\$44.89	\$42.30	\$58.73
66	\$4.07	\$5.80	\$13.54	\$17.86	\$23.70	\$32.35	\$33.86	\$46.84	\$44.03	\$61.33
67	\$4.24	\$6.06	\$13.97	\$18.51	\$24.57	\$33.65	\$35.16	\$48.79	\$45.76	\$63.92
68	\$4.41	\$6.31	\$14.40	\$19.16	\$25.43	\$34.95	\$36.46	\$50.73	\$47.49	\$66.52
69	\$4.67	\$6.66	\$15.05	\$20.02	\$26.73	\$36.68	\$38.41	\$53.33	\$50.08	\$69.98
70	\$4.93	\$7.01	\$15.70	\$20.89	\$28.03	\$38.41	\$40.35	\$55.92	\$52.68	\$73.44
71	\$5.28	\$7.53	\$16.56	\$22.19	\$29.76	\$41.00	\$42.95	\$59.81	\$56.14	\$78.63
72	\$5.62	\$8.04	\$17.43	\$23.48	\$31.49	\$43.60	\$45.54	\$63.71	\$59.60	\$83.82
73	\$5.97	\$8.56	\$18.29	\$24.78	\$33.22	\$46.19	\$48.14	\$67.60	\$63.06	\$89.01
74	\$6.31	\$9.08	\$19.16	\$26.08	\$34.95	\$48.79	\$50.73	\$71.49	\$66.52	\$94.20
75	\$6.75	\$9.60	\$20.24	\$27.38	\$37.11	\$51.38	\$53.98	\$75.38	\$70.84	\$99.39
76	\$7.61	\$10.73	\$22.40	\$30.19	\$41.43	\$57.00	\$60.46	\$83.82	\$79.49	\$110.63
77	\$8.48	\$11.85	\$24.57	\$33.00	\$45.76	\$62.63	\$66.95	\$92.25	\$88.14	\$121.88
78	\$9.34	\$12.98	\$26.73	\$35.81	\$50.08	\$68.25	\$73.44	\$100.69	\$96.79	\$133.12
79	\$10.21	\$14.19	\$28.89	\$38.84	\$54.41	\$74.30	\$79.93	\$109.77	\$105.44	\$145.23
80	\$11.07	\$15.40	\$31.05	\$41.87	\$58.73	\$80.36	\$86.41	\$118.85	\$114.09	\$157.34

Issue Age	Male									
	Per \$1,000		\$2,500		\$5,000		\$7,500		\$10,000	
	NS	S	NS	S	NS	S	NS	S	NS	S
65	\$4.93	\$7.27	\$15.70	\$21.54	\$28.03	\$39.70	\$40.35	\$57.87	\$52.68	\$76.03
66	\$5.28	\$7.79	\$16.56	\$22.84	\$29.76	\$42.30	\$42.95	\$61.76	\$56.14	\$81.22
67	\$5.62	\$8.39	\$17.43	\$24.35	\$31.49	\$45.33	\$45.54	\$66.30	\$59.60	\$87.28
68	\$5.97	\$9.00	\$18.29	\$25.86	\$33.22	\$48.35	\$48.14	\$70.84	\$63.06	\$93.33
69	\$6.31	\$9.60	\$19.16	\$27.38	\$34.95	\$51.38	\$50.73	\$75.38	\$66.52	\$99.39
70	\$6.66	\$10.21	\$20.02	\$28.89	\$36.68	\$54.41	\$53.33	\$79.93	\$69.98	\$105.44
71	\$7.09	\$10.99	\$21.11	\$30.84	\$38.84	\$58.30	\$56.57	\$85.76	\$74.30	\$113.23
72	\$7.53	\$11.76	\$22.19	\$32.78	\$41.00	\$62.19	\$59.81	\$91.60	\$78.63	\$121.01
73	\$8.04	\$12.54	\$23.48	\$34.73	\$43.60	\$66.09	\$63.71	\$97.44	\$83.82	\$128.80
74	\$8.56	\$13.49	\$24.78	\$37.11	\$46.19	\$70.84	\$67.60	\$104.58	\$89.01	\$138.31
75	\$9.17	\$14.45	\$26.30	\$39.49	\$49.22	\$75.60	\$72.14	\$111.71	\$95.06	\$147.83
76	\$10.47	\$16.18	\$29.54	\$43.81	\$55.71	\$84.25	\$81.87	\$124.69	\$108.04	\$165.13
77	\$11.76	\$17.91	\$32.78	\$48.14	\$62.19	\$92.90	\$91.60	\$137.66	\$121.01	\$182.43
78	\$13.06	\$19.64	\$36.03	\$52.46	\$68.68	\$101.55	\$101.33	\$150.64	\$133.99	\$199.73
79	\$14.36	\$21.37	\$39.27	\$56.79	\$75.17	\$110.20	\$111.07	\$163.61	\$146.96	\$217.03
80	\$15.74	\$23.10	\$42.73	\$61.11	\$82.09	\$118.85	\$121.45	\$176.59	\$160.80	\$234.33

To estimate the monthly premium for face amounts other than \$2,500, \$5,000, \$7,500, or \$10,000, multiply the “Per \$1,000” factor by the desired face amount, divide by \$1,000 and add a \$3.37 monthly policy fee.

For quarterly premium mode, multiply the monthly premium by 3.01

For semi-annual premium mode, multiply the monthly premium by 5.95

For annual premium mode, multiply the monthly premium by 11.56

Calculate your premium

Forethought® Medicare Supplement

Medicare Supplement Plan _____

Before you begin: *If you're not in your open enrollment or guarantee issue period, please go to page 2 to determine your eligibility for coverage.*

Steps	Example	Applicant's premium	Applicant B's premium
Premium Write in your Medicare Supplement Plan's premium from the Outline of Coverage table.	\$128.52		
Payment Options To determine other payment schedules, multiply your monthly premium by: 3 to pay four times a year (quarterly) 6 to pay twice a year (semi-annually) 12 to pay once a year (annually)	\$128.52 Monthly payment \$385.56 Quarterly payment \$771.12 Semi-annual payment \$1,542.24 Annual payment		
Enrollment/Policy fee There is a one-time application fee of \$25.00 This will be collected with your initial payment and will NOT affect your renewal premium.	\$128.52 + \$25.00 = \$153.52 Example shows initial payment (monthly schedule).		

Calculate your premium

Forethought® Life Insurance

TO ADD FORETHOUGHT® FREEDOMSM

For total face amounts other than \$2,500, \$5,000, \$7,500, or \$10,000, multiply the "Per \$1,000" column by the number of units applied for and add the \$3.37 monthly policy fee to your calculation.		Applicant's premium calculation	Applicant B's premium calculation
Choose the base face amount of life insurance coverage you want to purchase (\$2,500, \$5,000, \$7,500 or \$10,000)	Base face amount \$5,000 (Example based on Male age 75 non-smoker)	Premium amount \$49.22	
Add any additional \$1,000 Face Amount increments	1 Additional \$1,000 increment x \$9.17 per \$1,000	Total additional increment premium = \$9.17	
Payment Options Multiply monthly premium by: 3.01 for a quarterly premium 5.95 for a semi-annual premium 11.56 for an annual premium BILLING MODE MUST BE THE SAME AS THE MEDICARE SUPPLEMENT BILLING MODE	\$49.22 base premium + \$9.17 additional increment \$58.39 total monthly premium for life insurance x3.01 (Quarterly) = \$175.75 x5.95 (Semi-annual)=\$347.42 x11.56 (Annual) = \$674.99	Total life premium \$49.22 + \$9.17 \$58.39	
Add the Medicare Supplement (from top section) and Life Insurance premiums (this section) together	\$153.52 (Med Supp) + \$58.39 (Life Ins) \$211.91	One check payable to Forethought Life Insurance Company for \$211.91	

COMPLETE AND RETURN WITH APPLICATION

Height and weight charts

To determine whether you may purchase coverage, locate your height, then weight in the charts below. If you are applying for Medicare Supplement coverage and your weight is not in the Standard column in the Forethought® Medicare Supplement chart, you're not eligible for Medicare Supplement coverage at this time. If your weight is located in the Standard column, you may proceed in completing the application for Medicare Supplement coverage. If you are applying for life insurance coverage and your current weight is equal to or less than what is listed in the Forethought® FreedomSM Life Insurance coverage chart, you are eligible for the coverage noted and you may proceed in completing the application for life insurance coverage accordingly.

FORETHOUGHT® MEDICARE SUPPLEMENT

FORETHOUGHT® FREEDOMSM LIFE INSURANCE

	Decline	Standard	Decline
Height	Weight	Weight	Weight
4' 2"	< 54	54 – 145	146 +
4' 3"	< 56	56 – 151	152 +
4' 4"	< 58	58 – 157	158 +
4' 5"	< 60	60 – 163	164 +
4' 6"	< 63	63 – 170	171 +
4' 7"	< 65	65 – 176	177 +
4' 8"	< 67	67 – 182	183 +
4' 9"	< 70	70 – 189	190 +
4' 10"	< 72	72 – 196	197 +
4' 11"	< 75	75 – 202	203 +
5' 0"	< 77	77 – 209	210 +
5' 1"	< 80	80 – 216	217 +
5' 2"	< 83	83 – 224	225 +
5' 3"	< 85	85 – 231	232 +
5' 4"	< 88	88 – 238	239 +
5' 5"	< 91	91 – 246	247 +
5' 6"	< 93	93 – 254	255 +
5' 7"	< 96	96 – 261	262 +
5' 8"	< 99	99 – 269	270 +
5' 9"	< 102	102 – 277	278 +
5' 10"	< 105	105 – 285	286 +
5' 11"	< 108	108 – 293	294 +
6' 0"	< 111	111 – 302	303 +
6' 1"	< 114	114 – 310	311 +
6' 2"	< 117	117 – 319	320 +
6' 3"	< 121	121 – 328	329 +
6' 4"	< 124	124 – 336	337 +
6' 5"	< 127	127 – 345	346 +
6' 6"	< 130	130 – 354	355 +
6' 7"	< 134	134 – 363	364 +
6' 8"	< 137	137 – 373	374 +
6' 9"	< 140	140 – 382	383 +
6' 10"	< 144	144 – 392	393 +
6' 11"	< 147	147 – 401	402 +
7' 0"	< 151	151 – 411	412 +
7' 1"	< 155	155 – 421	422 +
7' 2"	< 158	158 – 431	432 +
7' 3"	< 162	162 – 441	442 +
7' 4"	< 166	166 – 451	452 +

HEIGHT		WEIGHT & COVERAGE AVAILABLE		
Feet	Inches	Level	Graded	ROP
4	3	144	166	185
4	4	149	173	192
4	5	155	180	200
4	6	160	187	207
4	7	168	194	216
4	8	174	201	223
4	9	181	208	232
4	10	187	215	239
4	11	193	222	247
5	0	201	230	255
5	1	207	238	264
5	2	215	246	273
5	3	223	254	282
5	4	229	262	291
5	5	236	270	300
5	6	243	278	309
5	7	250	287	319
5	8	257	295	328
5	9	265	304	338
5	10	271	313	348
5	11	279	322	358
6	0	287	331	368
6	1	295	340	378
6	2	302	350	389
6	3	312	359	399
6	4	317	369	410
6	5	325	380	422
6	6	334	390	433
6	7	341	400	444
6	8	349	410	446
6	9	358	419	467
6	10	367	430	479
6	11	376	441	490

IMPORTANT NOTICE REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer and a copy left with the applicant if the applicant has existing life insurance policy(ies) or annuity contract(s).

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new policy involves the actual or intended use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacement before you make your purchase decision and ask that you answer the following questions and consider the questions provided with this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating an existing life insurance policy or annuity contract? Yes No
2. Are you considering using funds from your existing life insurance policies or annuity contracts to pay premiums due on the new policy or contract? Yes No

If you answered “no” to both questions, please sign and date the form on page 2.

If you answered “yes” to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing and complete the statement below:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

(Attach a sheet listing additional policies and/or contracts, if necessary)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation and a copy of this form. Be sure that you are making an informed decision.

If you replace or use values from an old policy or contract to purchase a new policy or contract you will have thirty (30) days from the date the new policy or contract is delivered to you to cancel that policy or contract to receive an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges or, in the case of a variable or market value adjustment contract, a payment of the cash surrender value provided under the contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under the contract.

The existing policy(ies) or contract(s) is being replaced because _____

I certify that the responses herein are, to the best of my knowledge, accurate.

Printed Name of Applicant _____ Printed Name of Joint Applicant (if applicable)

Applicant Signature _____ Joint Applicant's Signature

I do not want this notice read aloud to me. _____ / _____ / _____
(Applicants must initial only if they DO NOT want the notice read aloud) Applicant'(s) Initial's Date

I certify that the original or copies of all sales material used in connection with this application have been delivered to the applicant in accordance with the replacement regulations applicable to this jurisdiction and that only sales material approved by Forethought Life Insurance Company was used. I also certify that the responses herein are, to the best of my knowledge, accurate.

Printed Name of Product (s) _____

Producer's Signature _____ Date

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older – are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid – you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sale charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more or you could be turned down.
- Acquisition costs for the old policy may have been paid – you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sale charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid? more or you could be turned down.
- Acquisition costs for the old policy may have been paid – you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sale charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid? more or you could be turned down.
- Acquisition costs for the old policy may have been paid – you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sale charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor)
- Is there a benefit from favorable “grandfathered” treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

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You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new policy involves the actual or intended use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacement before you make your purchase decision and ask that you answer the following questions and consider the questions provided with this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating an existing life insurance policy or annuity contract? Yes No
2. Are you considering using funds from your existing life insurance policies or annuity contracts to pay premiums due on the new policy or contract? Yes No

If you answered “**no**” to both questions, please sign and date the form on page 2.

If you answered “**yes**” to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing and complete the statement below:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

(Attach a sheet listing additional policies and/or contracts, if necessary)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation and a copy of this form. Be sure that you are making an informed decision.

If you replace or use values from an old policy or contract to purchase a new policy or contract you will have thirty (30) days from the date the new policy or contract is delivered to you to cancel that policy or contract to receive an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges or, in the case of a variable or market value adjustment contract, a payment of the cash surrender value provided under the contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under the contract.

The existing policy(ies) or contract(s) is being replaced because _____

I certify that the responses herein are, to the best of my knowledge, accurate.

Printed Name of Applicant _____ Printed Name of Joint Applicant (if applicable)

Applicant Signature _____ Joint Applicant's Signature

I do not want this notice read aloud to me. _____ / _____ / _____
(Applicants must initial only if they DO NOT want the notice read aloud) Applicant's Initials Date

I certify that the original or copies of all sales material used in connection with this application have been delivered to the applicant in accordance with the replacement regulations applicable to this jurisdiction and that only sales material approved by Forethought Life Insurance Company was used. I also certify that the responses herein are, to the best of my knowledge, accurate.

Printed Name of Product (s) _____

Producer's Signature _____ Date

Forethought Life Insurance Company
Administrative Office
PO Box 14659 • Clearwater, FL 33766-4659

Notice to Applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Forethought 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. For your own information and protection, you should be aware of and seriously consider factors which may affect the insurance available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration and acceptance by the replacing insurer, you find that the 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 ISSUER, 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(s) (check one):

- Additional benefits.
 - No change in benefits, but lower premiums.
 - Fewer benefits and lower premiums.
 - 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) _____.
1. State laws provide that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

2. 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 any 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

Printed Name and Address of Issuer, Agent, or Broker

Applicant's Signature

Signature of Applicant B, if applying

Date

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Forethought Life Insurance Company
Administrative Office
PO Box 14659 • Clearwater, FL 33766-4659

Notice to Applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Forethought 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. For your own information and protection, you should be aware of and seriously consider factors which may affect the insurance available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration and acceptance by the replacing insurer, you find that the 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 ISSUER, 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(s) (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- 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) _____.

1. State laws provide that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

2. 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 any 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

PRINTED Name and Address of Issuer, Agent, or Broker

Applicant's Signature

Signature of Applicant B, if applying

Date

Forethought Life Insurance Company
PO Box 14659
Clearwater, FL 33766-4659

INVESTIGATIVE CONSUMER REPORT NOTICE TO APPLICANT

Federal law requires that notice of investigation be given to persons applying for insurance. In making this application for insurance to Forethought Life Insurance Company (the Company), it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living (the term "mode of living" does not relate directly or indirectly to the sexual orientation of any proposed insured). You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon proper identification, you have the right to inspect and/or receive a copy of the report from the consumer reporting agency. You have the right to make a written request to the Company within a reasonable period of time to receive additional detailed information about the nature and scope of the investigation. Write to: Underwriting Department, Forethought Life Insurance Company, P.O. Box 14659, Clearwater, Florida, 33766-6960.

MIB, INC. DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Forethought Life Insurance Company (the Company) or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The Company or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

MEDICARE SUPPLEMENT / SELECT INITIAL PREMIUM RECEIPT

MAKE CHECK PAYABLE TO: FORETHOUGHT LIFE INSURANCE COMPANY

Received from _____ (Proposed Insured) an application for a Medicare Supplement / Medicare Select Policy with Forethought Life Insurance Company (the Company), and \$ _____ for the initial premium. In the event the application is not accepted by the Company, the above amount will be refunded. No obligation is incurred by the Company unless said application is approved by the Company at its Administrative Office and a policy is issued.

Agent's Name (please print) _____

Agent's Signature _____

Date _____

Forethought Life Insurance Company

Consumers choosing to have initial premiums paid through ACH (Automated Clearing House) for Medicare Supplement Applications may have their initial premium automatically deducted from their checking or savings account through the Electronic Funds Transfer (EFT) process. When they do, you may fax the application and required forms instead of mailing them.

Follow these easy steps to submit Medicare Supplement Apps using ACH for the initial premium:

STEP 1 – COMPLETE THE AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER SECTION ON THE APPLICATION.

Applicants wishing to pay electronically will need to complete the appropriate Medicare Supplement Authorization for Electronic Funds Transfer section on the Application and include a voided check.

STEP 2 – FAX THE FOLLOWING ITEMS TO THE DEDICATED LINE FOR ACH PAYMENTS AT 1-855-808-0944

- 1) ACH fax transmittal cover sheet on the back of this form
- 2) Medicare Supplement and other required forms including authorization for EFT
- 3) Voided check for EFT

If you fax the application, do not mail it as processing errors occur and additional charges could result in the duplication.

For producer use only. Not for use with the general public.

THINKING AHEADSM **FORETHOUGHT[®]**

