PROVIDENT AMERICAN LIFE AND HEALTH INSURANCE COMPANY

2008 MEDICARE SUPPLEMENT INSURANCE PLANS

PACKET CONTAINS:

– **APPLICATION** PC-MA(R05A)-OR

– **BANK DRAFT FORM** PALHIC-9-0001

– **GUARANTEED ISSUE DETERMINATION** PC-MS-GIAPP

– **REPLACEMENT FORM** PC-M/S-REPLACE(R05)

– **OUTLINE OF COVERAGE** PC-OC(R07A)

FORMS FOR USE IN OREGON

EFFECTIVE DATE 5/1/08

PROVIDENT AMERICAN LIFE & HEALTH INSURANCE COMPANY | 6201 Johnson Drive, Mission, KS 66202
800-284-2898 www.palhic.com

PALHIC-1-0002-OR 4/1/08

FAXAPP COVER SHEET & TRANSMITTAL DOC

To: New Business

Please Check One and Fax to:

- ☐ **800.240.1806 – Central Reserve Applications**
- ☐ **888.216.5049 – Continental General Applications**
- ☐ **866.455.5550 – Provident American Applications**

Date: _____

From: _____

Your Telephone Number: _____

Agent Number	Plan	Proposed Insured	Premium Payor (if different than applicant)	CWA	Total

Total Number of applications faxed: _____

Total Number of pages faxed: _____

For detailed FaxApp instructions refer to the GASBG FaxApp Brochure (GASBG-9-0006)

GREAT AMERICAN FINANCIAL RESOURCES
Supplemental Benefits Group

Central Reserve Life Insurance Company
Continental General Life Insurance Company
Provident American Life & Health Insurance Company

MEDICARE SUPPLEMENT
INSURANCE APPLICATION TO

PROVIDENT AMERICAN LIFE AND HEALTH INSURANCE COMPANY
6201 Johnson Drive, P.O. Box 29158, Mission, Kansas 66201-9158

Name of Proposed Insured (Print) First Initial Last	Sex	Birthdate Mo.	Day	Year	Age	Social Security No.			Medicare Card No.
Resident Street Address (No P.O. Box)	City				State		Zip		Telephone No.
Premium Payor Address (if other than the insured)	City				State		Zip		Telephone No.

COVERAGE APPLIED FOR

Check plan selected:
- ☐ Plan A
- ☐ Plan D
- ☐ Plan F
- ☐ Plan F* (High Deductible)
- ☐ Plan G
- ☐ Plan H
- ☐ Plan I
- ☐ Plan J

Check premium payment mode selected:
- ☐ Annual
- ☐ Semi-Annual
- ☐ Quarterly
- ☐ Monthly BOM
- ☐ _____ (Other)

Amount of Premium Submitted with the Application: $ _____ (Check must be made payable to Provident American Life And Health Insurance Company).

Requested Effective Date: _____

OPEN ENROLLMENT – FEDERAL LAW REQUIRES THAT A 6-MONTH OPEN ENROLLMENT PERIOD BE PROVIDED TO AN APPLICANT WHO IS: (1) AGE 65 OR OLDER WHEN FIRST ENROLLING IN MEDICARE PART B; OR (2) AGE 65 AND PREVIOUSLY ENROLLED IN MEDICARE PART B. IF APPLICANT QUALIFIES FOR OPEN ENROLLMENT, DO NOT ANSWER THE FOLLOWING MEDICAL QUESTIONS IN A.

A. If the answer to any question in this section is "Yes" the proposed insured is not eligible for coverage.	Yes	No
1. Are you currently confined in a hospital or nursing facility, or receiving the services of a home health agency?	☐	☐
2. Has surgery been advised but not performed?	☐	☐
3. Is surgery anticipated within the next 12 months?	☐	☐
4. Are you bedridden or do you use the assistance of a wheelchair or walker?	☐	☐
5. Within the past two years have you:		
a. Been confined to a nursing facility?	☐	☐
b. Been hospitalized more than 2 times?	☐	☐
c. Had any amputation caused by disease?	☐	☐
6. Do you have now, or have you received medical advice, treatment, or been advised to have treatment, surgery, or take medication for the following conditions:		
A) At any time for:		
1. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Dementia, or Alzheimer's Disease or Organic Brain Disorder?	☐	☐
2. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human immunodeficiency virus (HIV) infection?	☐	☐

6. (continued from Page 1)

B) Within the past two (2) years for:

	Yes	No
1. Insulin Dependent Diabetes, Uncontrolled Diabetes, Chronic Kidney Disease, Renal Insufficiency, Renal Failure, or any Kidney Disease requiring dialysis?	☐	☐
2. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic Obstructive Lung Disease (COLD) excluding Asthma, or any Chronic Pulmonary Disease Requiring the use of oxygen?	☐	☐
3. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma?	☐	☐
4. Heart Attack, Heart or Heart Valve Surgery, Congestive Heart Failure, Peripheral Vascular Disease, Aneurysm, or Cardiac Pacemaker or Defibrillating Device?	☐	☐
5. Stroke or Transient Ischemic Attack (TIA)?	☐	☐
6. Cirrhosis of the Liver, Hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment?	☐	☐
7. Alcohol or Drug Abuse?	☐	☐
8. Paget's Disease, Rheumatoid or Disabling Arthritis, Lupus or other bone or Connective tissue disorder?	☐	☐

Phone interviews will be used on the non-open enrollee/Guarantee Issue applicants.

Daytime Phone # _____

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

B. If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. (Please mark Yes or No below with an "X".)

To the best of your knowledge,

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

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

   c) If yes, what is the effective date? _____

2. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Costs", please answer NO to this question). ..... ☐ Yes ☐ No

If "Yes":

a) Will Medicaid pay your premiums for this Medicare supplement policy? ..... ☐ Yes ☐ No

b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ..... ☐ Yes ☐ No

3. a) 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 ____/____/____ END ____/____/____

b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?..... ☐ Yes ☐ No

c) Was this your first time in this type of Medicare plan? ..... ☐ Yes ☐ No

d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ..... ☐ Yes ☐ No

4. a) Do you have another Medicare supplement policy in force? ..... ☐ Yes ☐ No

b) If so, with what company, and what plan do you have? _____

_____

c) If so, do you intend to replace your current Medicare supplement policy with this policy? ..... ☐ Yes ☐ No

If existing Medicare supplement coverage is not to be replaced, this policy cannot be issued.

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

a) If so, with what company and what kind of policy? _____

_____

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

C. Do you now have Medicare Parts A and B? ..... ☐ Yes ☐ No

If yes, give effective date of Part B:_____ .

D. If Medicare Parts A and B are to be effective at a future date, provide the date both Medicare Parts A and B will be effective _____ .

NOTE – Medicare effective date is always the 1st day of the month**. Applicant must have both Medicare Parts A & B on the effective date of the policy. If not, coverage cannot be issued.**

I have received the Outline of Coverage for the policy applied for and the required Guide to Health Insurance for People with Medicare ..... ☐ YES ☐ NO

I hereby apply to Provident American Life And Health Insurance Company, Mission, KS, for insurance to be issued upon the truth and completeness of the answers to the above questions to the best of my knowledge, and agree that: (1) No agent has the authority to waive the answer to any question in the application; and (2) no insurance will be effective until a policy has been issued.

AUTHORIZATION

I hereby authorize any health care provider, including any physician, practitioner, pharmacy, prescription vendor, pharmacy benefit manager, hospital or medically-related facility, and any insurance company, the Medical Information Bureau (MIB) or other consumer reporting agency, employer, or, except in AZ, any other organization, institution or person that has my records or knowledge of me or my dependent(s) to disclose to PALHIC, or its authorized representative, any such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by company personnel to determine eligibility for insurance and/or benefits. PALHIC may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. However, PALHIC shall not disclose to an agent information received from MIB. PALHIC reserves the right to require a medical examination or testing or both. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask PALHIC to correct, amend or delete any incorrect personal information. A copy of the Company's "Privacy Notice and Notice of Insurance Information Practices" is available upon request.

This authorization shall be valid for a period of two (2) years from the date signed to determine eligibility for insurance or for the term of coverage of the policy to determine benefits. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to the Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke also is subject to the rights of the Company under any law granting the Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Dated at: _____ Date: _____

City State (MMDDYY)

Signature of Applicant: Date:

Signature of Authorized Representative: Relationship/ Authority to Represent Date:

Authorized Representative's Address:

Authorized Representative's Phone Number:

INVESTIGATIVE CONSUMER REPORTS AUTHORIZATION

As part of our normal procedure for processing your application, an investigative consumer report may be prepared whereby information is obtained as to the character, general reputation, personal characteristics and mode of living of persons proposed for insurance in this application. Personal interviews with friends, neighbors and associates may be used to develop this report. (In WV, no information collected concerning the sexual orientation of the proposed insured will be used to determine his or her eligibility for insurance.) You may request to be interviewed in connection with the preparation of the report. You have the right to request "A Summary of Your Rights Under the Fair Credit Reporting Act". Upon written request, you or your representatives have a right to receive a copy of the report and additional information about the nature and scope of the investigation.

AGENT'S CERTIFICATE

1. List the health policies you sold to this applicant which are still in force: (If this does not apply, state NONE).

_____

_____

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

_____

_____

3. (a) Have you reviewed the application for correctness and omissions? ..... ☐ YES ☐ NO
   (b) Was application completed by you in the applicant's presence? ..... ☐ YES ☐ NO
   (c) Do you have knowledge or reason to believe the replacement of existing insurance may be involved? ..... ☐ YES ☐ NO

If "YES" give Name of Company, reason and termination date _____

_____

I certify that I saw the applicant and truly and accurately recorded, in the applicant's presence, all the information supplied me by the applicant.

Signature of Licensed Resident Agent

_____ / _____ # _____

Print Name **Signature**

CAUTION: Please review your answers to the questions on this application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

PROVIDENT AMERICAN LIFE &
HEALTH INSURANCE COMPANY | 6201 Johnson Drive, Mission, KS 66202
800-284-2898 www.palhic.com

BANK AUTHORIZATION

☐ Checking ☐ Savings ☐ Special Bill Date_____

PROVIDENT AMERICAN LIFE & HEALTH INSURANCE COMPANY is hereby requested and authorized to draw checks to be charged against the checking or savings account of:

_____ with _____
print name as shown on bank records — name of bank and branch name, if any

Bank Routing Number: _____ Bank Account Number: _____

for the purpose of collecting premiums payable to PROVIDENT AMERICAN LIFE & HEALTH INSURANCE COMPANY under the bank check premium arrangement. The policy(ies) are to be placed under the bank check premium arrangement, upon approval by the Company, for premiums due. It is understood that PROVIDENT AMERICAN LIFE & HEALTH INSURANCE COMPANY'S premium arrangement may be terminated by the policy owner or by the Company upon written notice.

As a convenience to me, I hereby request and authorize the bank named above to pay and charge my account debits drawn by Provident American Life & Health Insurance Company to its own order. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such debit. I agree that your treatment of each such check, and your rights in respect to it, shall be the same as if it were signed personally by me. I further agree that if any such check be dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____ _____
date — signature of bank depositor/premium payor
(as shown on bank records for the account to which this authorization is applicable)

INDEMNIFICATION AGREEMENT

To: The Bank Named Above

In consideration of your participation in a plan which the PROVIDENT AMERICAN LIFE & HEALTH INSURANCE COMPANY has put in effect by which amounts for premiums due on policies of insurance are collected by drafts drawn by the company on the accounts of persons who have made themselves responsible for these payments, the Company does hereby agree that subject to the terms and provisions of such insurance policies without varying, extending or altering the terms, thereof:

(1) It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any check drawn by the Company on the account of such person, or arising out of the dishonor by you, whether with or without cause or intentionally or inadvertently, of any such check drawn by the Company, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture, of a policy of insurance the premium on which is sought to be collected by the Company by any such check; and

(2) It will refund to you any amount erroneously paid by you on any such check if claim for the amount of such erroneous payment is made by you within a reasonable time from the date of the check on which such erroneous payment was made.

Billy Hill Jr.

_____
(authorized Officer's signature) President

Please Note: A VOIDED check must accompany the authorization.

PROVIDENT AMERICAN LIFE AND HEALTH INSURANCE COMPANY
6201 JOHNSON DRIVE
PO BOX 29158
MISSION, KANSAS 66201-9158

GUARANTEED ISSUE DETERMINATION

COMPLETE ONLY IF APPLYING FOR A MEDICARE SUPPLEMENT POLICY ON A GUARANTEED ISSUE BASIS

For any applicant to be considered eligible for a Medicare Supplement policy on a guaranteed issue basis, other than during an open enrollment period, the following information and appropriate documentation must be provided, in addition to completion of the application for Medicare Supplement insurance.

Prior Coverage-Employee Welfare Benefit Plan

Within the last 63 days, did your employee welfare benefit plan terminate all benefits supplementing Medicare?

Proposed Insured: [ ] Yes [ ] No

If you answer "yes", you are eligible for Medicare Supplement Plans A, B, C or F on a guaranteed issue basis.

Prior Coverage- Medicare+Choice Plan That Had Been Elected Upon Initial Eligibility for Medicare Part A at age 65

Within the last 63 days, did you terminate enrollment from a Medicare+Choice plan, having enrolled in such plan upon initial eligibility for Medicare Part A at age 65 and subsequently disenrolled within 12 months of enrollment?

Proposed Insured: [ ] Yes [ ] No

If you answer "yes", you are eligible for any Medicare Supplement policy offered by the company on a guaranteed issue basis.

Prior Coverage – First time Enrollment in Medicare Select Policy, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan or Medicare+Choice Plan After Termination of Medicare Supplement coverage

1. Within the last 12 months, did you terminate Medicare Supplement coverage to enroll for the first time in a Medicare Select Plan, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan or Medicare+Choice Plan?
   Proposed Insured: [ ] Yes [ ] No

   If "yes", with what Company?_____ Policy No._____

2. Within the past 63 days, did you terminate enrollment in such plan?
   Proposed Insured: [ ] Yes [ ] No

If you answer "yes" to questions 1. and 2., you are eligible for the same Medicare Supplement plan, on a guaranteed issue basis, that you had prior to the election of the coverage that most recently terminated. However, application must be made to the same insurer that provided the Medicare Supplement coverage. If that insurer does not have that plan available, then you are eligible for a Medicare Supplement Plan A, B, C or F from this company on a guaranteed issue basis.

Prior Coverage – Medicare Select Policy, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Prepayment Plan or Medicare+Choice Plan

Within the the last 63 days, did you discontinue enrollment in Medicare Select policy, Medicare HMO, Medicare Demonstration Project, Medicare Health Care Payment Plan or Medicare+Choice Plan because:

a. the plan's certification was terminated or the plan was discontinued in the area in which you live?
   Proposed Insured: [ ] Yes [ ] No

b. you changed your place of residence or there was another change in circumstance (other than nonpayment of premium) which made you ineligible for the plan:
Proposed Insured: [ ] Yes [ ] No

c. you have satisfactorily demonstrated that the organization substantially violated a material provision of the plan with respect to your care?
Proposed Insured: [ ] Yes [ ] No

d. you have satisfactorily demonstrated that the organization, agent or other entity acting on the plan's behalf, materially misrepresented the plan's provision in the marketing of the plan to you?
Proposed Insured: [ ] Yes [ ] No

If you answer "yes" to any questions a. – d., you are eligible for Medicare Supplement Plans A, B, C or F on a guaranteed issue basis.

Prior Coverage – Medicare Supplement Policy

Within the last 63 days, did your Medicare Supplement policy terminate because:

a. the insurer went bankrupt, became insolvent, or involuntarily terminated the plan and there is no state law or regulation for continuation or conversion of such coverage?
Proposed Insured: [ ] Yes [ ] No

b. you have satisfactorily demonstrated that the insurer substantially violated a material provision of the policy with respect to your care?
Proposed Insured: [ ] Yes [ ] No

c. you have satisfactorily demonstrated that the insurer, agent or entity acting on the company's behalf, materially misrepresented the policy's provisions in marketing the plan to you?
Proposed Insured: [ ] Yes [ ] No

If you answer "yes" to any questions you are eligible for Medicare Supplement Plans A, B, C or F on a guaranteed issue basis.

If you are eligible for a Medicare Supplement policy on a guaranteed issue basis, you must provide appropriate documentation of your termination of or disenrollment from coverage along with your application for the Medicare Supplement policy. Appropriate documentation includes written information that identifies the plan of coverage, the date of the termination of or disenrollment from coverage and the reason for termination.

To the best of my knowledge and belief, the information provided above is true and correct. I understand that this application will become part of my application for coverage, and thus part of the policy. The company may investigate my responses to the questions, and the documentation that I provided.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or any application containing any false, incomplete or misleading information may be guilty of insurance fraud.

Applicant_____
(Please Print)

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

PROVIDENT AMERICAN LIFE AND HEALTH INSURANCE COMPANY
6201 Johnson Drive, P.O. Box 29158
Mission, Kansas 66201-9158

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

According to your application or information you have furnished, you intend to lapse or otherwise terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Provident American Life and Health Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep this policy.

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

STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE):

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

_____ Additional benefits.
_____ No change in benefits, but lower premiums.
_____ Fewer benefits and lower premiums.
_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
_____
_____
_____ Other (Please Specify).
_____

HOME OFFICE COPY

(1) **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy to the extent such time was spent (depleted) under the original policy.

(3) 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/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. **AFTER THE APPLICATION HAS BEEN COMPLETED AND BEFORE YOU SIGN IT, REVIEW IT CAREFULLY TO BE CERTAIN THAT ALL INFORMATION HAS BEEN PROPERLY RECORDED.**

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

_____

(Signature of Agent, Broker or Other Representative)

_____

(Typed Name and Address of Agent or Broker)

The above “Notice to Applicant” was delivered to me on:

_____

(Date)

_____

(Applicant’s Signature)

Applicant_____
(Please Print)

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

PROVIDENT AMERICAN LIFE AND HEALTH INSURANCE COMPANY
6201 Johnson Drive, P.O. Box 29158
Mission, Kansas 66201-9158

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

According to (your application or information you have furnished), you intend to lapse or otherwise terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Provident American Life and Health Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep this policy.

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

STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE):

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

_____ Additional benefits.
_____ No change in benefits, but lower premiums.
_____ Fewer benefits and lower premiums.
_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
_____
_____
_____ Other (Please Specify).
_____

APPLICANT'S COPY

(1) **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy to the extent such time was spent (depleted) under the original policy.

(3) 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/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. **AFTER THE APPLICATION HAS BEEN COMPLETED AND BEFORE YOU SIGN IT, REVIEW IT CAREFULLY TO BE CERTAIN THAT ALL INFORMATION HAS BEEN PROPERLY RECORDED.**

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

_____

(Signature of Agent, Broker or Other Representative)

_____

(Typed Name and Address of Agent or Broker)

The above “Notice to Applicant” was delivered to me on:

_____

(Date)

_____

(Applicant’s Signature)

PROVIDENT AMERICAN LIFE AND HEALTH INSURANCE COMPANY
6201 Johnson Drive, P.O. Box 29158, Mission, Kansas 66201-9158

Outline of Medicare Supplement Coverage — Cover Page: 1 of 2

Benefit Plans A, D, F, F*, G, H, I and J are offered

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

See Outlines of Coverage Sections for details about ALL plans

BASIC BENEFITS for Plans A – J: Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end. Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Blood: First three pints of blood each year.

A	B	C	D	E	F -- F*	G	H	I	J -- J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year $1,900 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed $1,900. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

PROVIDENT AMERICAN LIFE AND HEALTH INSURANCE COMPANY
6201 Johnson Drive, P.O. Box 29158, Mission, Kansas 66201-9158

Outline of Medicare Supplement Coverage — Cover Page: 2

Basic Benefits for Plans K and L include similar services as Plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Co-insurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B co-insurance, except 100% Co-insurance for Part B Preventive Services	100% of Part A Hospitalization Co-insurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B co-insurance, except 100% Co-insurance for Part B Preventive Services
Skilled Nursing Facility Co-Insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$4,440 Out of Pocket Annual Limit***	$2,220 Out of Pocket Annual Limit***

** Plans K and L provide for different cost-sharing for items and services than Plans A – J.
Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

PREMIUM INFORMATION

At your current attained age (age at last birthday), premiums for each benefit plan offered will be:

PLAN A

Annual $ _____

Semi-Annual $ _____

Quarterly $ _____

Bank Draft $ _____

PLAN D

Annual $ _____

Semi-Annual $ _____

Quarterly $ _____

Bank Draft $ _____

PLAN F

Annual $ _____

Semi-Annual $ _____

Quarterly $ _____

Bank Draft $ _____

PLAN F High Deductible

Annual $ _____

Semi-Annual $ _____

Quarterly $ _____

Bank Draft $ _____

PLAN G

Annual $ _____

Semi-Annual $ _____

Quarterly $ _____

Bank Draft $ _____

PLAN H

Annual $ _____

Semi-Annual $ _____

Quarterly $ _____

Bank Draft $ _____

PLAN I

Annual $ _____

Semi-Annual $ _____

Quarterly $ _____

Bank Draft $ _____

PLAN J

Annual $ _____

Semi-Annual $ _____

Quarterly $ _____

Bank Draft $ _____

PROVIDENT AMERICAN LIFE AND HEALTH INSURANCE COMPANY

OREGON
MEDICARE SUPPLEMENT

2008 Attained Age Annual Premiums
Female Rates

Attained Age	Plan A	Plan D	Plan F	Plan G	Plan H	Plan I	Plan J	Plan HDF
< 65	$1,424	$1,556	$1,728	$1,562	$1,274	$1,526	$1,597	$587
65	1,424	1,556	1,728	1,562	1,274	1,526	1,597	587
66	1,486	1,623	1,803	1,562	1,274	1,526	1,597	611
67	1,540	1,683	1,869	1,562	1,274	1,526	1,597	634
68	1,603	1,750	1,943	1,625	1,324	1,587	1,661	660
69	1,663	1,817	2,018	1,687	1,374	1,647	1,725	685
70	1,724	1,884	2,092	1,748	1,423	1,707	1,788	710
71	1,786	1,947	2,163	1,808	1,472	1,766	1,849	736
72	1,840	2,008	2,231	1,865	1,518	1,822	1,908	759
73	1,891	2,066	2,296	1,917	1,559	1,872	1,962	781
74	1,940	2,116	2,351	1,964	1,599	1,918	2,009	801
75	1,988	2,168	2,409	2,012	1,636	1,965	2,059	818
76	2,023	2,208	2,454	2,049	1,665	2,001	2,097	834
77	2,060	2,249	2,498	2,088	1,697	2,039	2,135	849
78	2,101	2,293	2,548	2,129	1,729	2,079	2,178	864
79	2,138	2,334	2,594	2,167	1,760	2,116	2,218	881
80	2,176	2,375	2,639	2,205	1,791	2,154	2,255	896
81	2,212	2,414	2,682	2,242	1,820	2,189	2,293	911
82	2,250	2,454	2,726	2,277	1,848	2,224	2,330	927
83	2,282	2,492	2,769	2,314	1,877	2,260	2,367	941
84	2,317	2,528	2,809	2,348	1,905	2,293	2,401	956
85 +	2,344	2,560	2,845	2,379	1,930	2,324	2,431	967

The Following Apply:

1. Area Factors:

Zip Code	Area Factor
970-972, 974.....	0.80
ELSE.....	0.75

2. Males - add 15%

3. All adjustment factors are multiplicative

4. Modal Factors:

Semi-Annual	0.520
Quarterly	0.265
Monthly Bank Draft	0.085

5. Add an additional $25.00 policy fee to the initial premium

PREMIUM INFORMATION

We, the Provident American Life and Health Insurance Company (PALHIC), may change the premium rates for this policy. We can only raise your premium if we raise the premium by class for all policies like yours in the State. Premiums will automatically increase each year on the policy's anniversary date reflecting the increasing age of each Covered Person.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline which describes 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 your insurance company.

RIGHT TO RETURN POLICY

If you are not satisfied with your policy, you may return it to Us at the address shown on Page 1. If you send it 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 your payments.

POLICY REPLACEMENT

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

NOTICE

This policy may not fully cover all your medical costs.

Neither Provident American Life and Health 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 ON APPLICATION 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.

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 A PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,024	$0	$1,024 (Part A Deductible)
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	$0	Up to $128 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 Pints	$0	3 Pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer (PALHIC) stands in the 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 $135 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 A 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 $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 Pints	$0	All Costs	$0
Next $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-- Medically necessary skilled care services and medical supplies	100%	$0	$0
-- Durable medical equipment			
First $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,024	$1,024 (Part A Deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	Up to $128 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 Pints	$0	3 Pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer (PALHIC) stands in the 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 D

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

*Once you have been billed $135 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 D 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 $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 Pints	$0	All Costs	$0
Next $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE — Home care certified by your doctor for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
— Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
— Number of visits covered (must be received within eight weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar year maximum	$0	$1600	

PLAN D

OTHER BENEFITS — NOT COVERED BY MEDICARE

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

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,024	$1,024 (Part A Deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	Up to $128 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 Pints	$0	3 Pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer (PALHIC) stands in the 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 $135 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 F 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 $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 Pints	$0	All Costs	$0
Next $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0
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 amount of $50,000	20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE 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. **This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $1,900 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $1,900. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,900 DEDUCTIBLE,** PLAN F* PAYS	IN ADDITION TO $1,900 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,024	$1,024 (Part A Deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	Up to $128 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 Pints	$0	3 Pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer (PALHIC) stands in the 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.

HIGH DEDUCTIBLE PLAN F*

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

* Once you have been billed $135 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.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $1,900 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $1,900. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,900 DEDUCTIBLE,** PLAN F* PAYS	IN ADDITION TO $1,900 DEDUCTIBLE,** 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 $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 Pints	$0	All Costs	$0
Next $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0
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 amount of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN I PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,024	$1,024 (Part A Deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	Up to $128 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 Pints	$0	3 Pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer (PALHIC) stands in the 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 $135 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 I 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 $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 Pints	$0	All Costs	$0
Next $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $135 of Medicare Approved Amounts*	$0	$0	$135(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE — Home care certified by your doctor for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
— Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
— Number of visits covered (must be received within eight weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar year maximum	$0	$1600	

PLAN G

OTHER BENEFITS — NOT COVERED BY MEDICARE

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

PLAN H

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 H PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,024	$1,024 (Part A Deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	Up to $128 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 Pints	$0	3 Pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer (PALHIC) stands in the 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 H

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

*Once you have been billed $135 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 H 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 $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 Pints	$0	All Costs	$0
Next $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN H

OTHER BENEFITS — NOT COVERED BY MEDICARE

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

PLAN I

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 I PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,024	$1,024 (Part A Deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	Up to $128 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 Pints	$0	3 Pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer (PALHIC) stands in the 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 I

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

*Once you have been billed $135 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 I 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 $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 Pints	$0	All Costs	$0
Next $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE — Home care certified by your doctor for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
— Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
— Number of visits covered (must be received within eight weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar year maximum	$0	$1600	

PLAN I
OTHER BENEFITS — NOT COVERED BY MEDICARE

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

PLAN J

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 J PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,024	$1,024 (Part A Deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	Up to $128 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 Pints	$0	3 Pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer (PALHIC) stands in the 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 J

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

*Once you have been billed $135 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 J 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 $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 Pints	$0	All Costs	$0
Next $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
AT HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE — Home care certified by your doctor for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
— Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
— Number of visits covered (must be received within eight weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar year maximum	$0	$1600	

PLAN J
OTHER BENEFITS — NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN J PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	$0 $0	$0 80% to a lifetime maximum amount of $50,000	$250 20% and amounts over the $50,000 lifetime maximum
*PREVENTIVE MEDICAL CARE BENEFIT-- NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First $120 each calendar year Additional Charges	$0 $0	$120 $0	$0 All costs

* Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

OFFICIAL RECEIPT

PROVIDENT AMERICAN
LIFE AND HEALTH
INSURANCE COMPANY

UNLESS ACH FORM IS USED A CHECK OR MONEY ORDER MUST ACCOMPANY APPLICATION

Received of _____ this _____ day of _____(M) / _____(Y) , an application for a Form _____ Policy and Check or Money order for _____ Dollars. Should the Company decline to issue the insurance applied for, the Company herby agrees to return the above sum to the applicant.

_____ Agent

If the full premium is paid with the application and so recorded in the application and the Company shall be satisfied after investigation that the applicant was acceptable for the insurance applied for at the time the application was signed according to the underwriting rules of the Company the policy will be dated and effective according to its terms at 12:01 A.M. the day the application was dated or the date on which the premium was paid, whichever is later.