Notice To Applicant Regarding Replacement Of Medicare Supplement Insurance Or Medicare Advantage

Avalon Insurance Company
PO Box 772612
Harrisburg, PA 17177-2612
1-866-267-9874

Save this notice! It may be important to you in the future.
According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage and replace it with a policy to be issued by Avalon[SM] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this coverage carefully. Compare 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 issuer, producer (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(s) (check one):

- ❑ Additional benefits.
- ❑ No change in benefits, but lower premium.
- ❑ 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)

You may choose to make a copy for your records.

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Continued from front

To be completed by insurance producer or other representative

Signature of producer or other representative (A signature is not required for direct response sales)

Typed name and address of issuer, producer, or other representative

Applicant's signature | Date (MM/DD/YYYY)

Please read for important information

(A) If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement **(B)** 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.

(B) 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 (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(C) 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 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.

(D) Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.