GLOBE LIFE INSURANCE COMPANY OF NEW YORK

P.O. Box 3125 • Syracuse, NY • 13220

REPLACEMENT FORM

Health Insurance Policy – Comparison Form

Current Health or Medicare Policy

Name of Company: _____

Policy Number: _____

Premium: _____ Type: _____

Proposed GLNY Medicare Supplement Policy

Name of Company: **Globe Life Insurance Company of New York**

Application Number: _____

Premium: _____ Type: _____

Applicant's Name: _____

1. Does the insurer provide a service for an automatic filing of both assigned and unassigned Part B claims?

Current Policy ☐ Yes ☐ No

GLNY Policy ☐ Yes ☐ No

2. If the current policy is a standardized Medicare Supplement Plan under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), identify the plan category as A, B, C, D, F, High Deductible F, G, High Deductible G, K, L, M, or N.

ProCare Plan

Current Plan	A	B	C	D	F	F+	G	G+	K	L	N
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

There is no need to complete the rest of this form if the current policy is a standardized Plan.

3. If the current policy is not a standardized Plan, answer the following questions for the current policy only.

	Current Policy	GLNY Policy (**Y** = Yes, ℕ = No)										
Part A		A	B	C▼	D	F▼	F+▼	G	G+	K	L	N
Pays Medicare Part A Deductible?	☐ Yes ☐ No	ℕ	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	50%	75%	**Y**
Pays all expenses after Medicare Part A is exhausted up to 365 days?	☐ Yes ☐ No	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Has a Skilled Nursing Facility benefit?	☐ Yes ☐ No	ℕ	ℕ	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	50%	75%	**Y**
Part B		A	B	C▼	D	F▼	F+▼	G	G+	K	L	N
Pays Medicare Part B Deductible?	☐ Yes ☐ No	ℕ	ℕ	**Y**	ℕ	**Y**	**Y**	ℕ	ℕ	ℕ	ℕ	ℕ
Pays ALL Medicare Part B coinsurance amounts?	☐ Yes ☐ No	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	*	*	**
Pays 100% of excess charges *(amounts above Medicare approved)*?	☐ Yes ☐ No	ℕ	ℕ	ℕ	ℕ	**Y**	**Y**	**Y**	**Y**	ℕ	ℕ	ℕ
Has a Foreign Travel Benefit?	☐ Yes ☐ No	ℕ	ℕ	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	ℕ	ℕ	**Y**
Is Policy Guaranteed Renewable?	☐ Yes ☐ No	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Prescription Drug Benefit?	☐ Yes ☐ No	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ
Preventive Care Benefit?	☐ Yes ☐ No	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ

Other Benefits or Services (itemize) _____

* Once you meet out-of-pocket annual limit

** Subject to policy copayment for office visits and emergency room visits

▼ Only applicants first eligible for Medicare before 2020 may purchase plans C, F, and High Deductible F

The Applicant's actual current policy ☐ **was** ☐ **was not** made available to me for review.

The Applicant's current policy ☐ **is** ☐ **is not** a Medicare Advantage Plan.

The Applicant's current policy ☐ **is** ☐ **is not** employer-provided coverage.

_____ _____

Agent's Signature and Agent Number — Date

_____ _____

Applicant's Signature — Date

A copy of this form must be returned with the application when a replacement of any health policy is involved in the sale of a GLNY Medicare Supplement policy.