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, K, L, M, or N.

Current Plan	ProCare Plan									
	A	B	C	D	F	F+	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.

GLNY Policy: **Y** = Yes N = No

Part A	Current Policy	A	B	C	D	F	F+	G	K	L	N
Pays Medicare Part A Deductible?	☐ Yes ☐ No	N	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
Has a Skilled Nursing Facility benefit?	☐ Yes ☐ No	N	N	Y	Y	Y	Y	Y	50%	75%	Y
Part B		A	B	C	D	F	F+	G	K	L	N
Pays Medicare Part B Deductible?	☐ Yes ☐ No	N	N	Y	N	Y	Y	N	N	N	N
Pays ALL Medicare Part B coinsurance amounts?	☐ Yes ☐ No	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	N	N	N
Has a Foreign Travel Benefit?	☐ Yes ☐ No	N	N	Y	Y	Y	Y	Y	N	N	Y
Is Policy Guaranteed Renewable?	☐ Yes ☐ No	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
Preventive Care Benefit?	☐ Yes ☐ No	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

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.

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Health Insurance Policy – Comparison Form

Current Health or Medicare Policy	**Proposed GLNY Medicare Supplement Policy**
Name of Company: ______	Name of Company: **Globe Life Insurance Company of New York**
Policy Number: ______	Application Number: ______
Premium: ______ Type: ______	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, K, L, M, or N.

Current Plan	**ProCare Plan**									
	A	B	C	D	F	F+	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.

GLNY Policy: **Y** = Yes N = No

Part A	**Current Policy**	A	B	C	D	F	F+	G	K	L	N
Pays Medicare Part A Deductible?	☐ Yes ☐ No	N	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
Has a Skilled Nursing Facility benefit?	☐ Yes ☐ No	N	N	Y	Y	Y	Y	Y	50%	75%	Y
Part B		A	B	C	D	F	F+	G	K	L	N
Pays Medicare Part B Deductible?	☐ Yes ☐ No	N	N	Y	N	Y	Y	N	N	N	N
Pays ALL Medicare Part B coinsurance amounts?	☐ Yes ☐ No	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	N	N	N
Has a Foreign Travel Benefit?	☐ Yes ☐ No	N	N	Y	Y	Y	Y	Y	N	N	Y
Is Policy Guaranteed Renewable?	☐ Yes ☐ No	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
Preventive Care Benefit?	☐ Yes ☐ No	N	N	N	N	N	N	N	N	N	N

Other Benefits or Services (itemize) ______

* Once you meet out-of-pocket annual limit
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______ Agent's Signature and Agent Number ______ Date

______ Applicant's Signature ______ Date

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