Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered YES, this form must be dated, signed by the applicant and by the Agent, and submitted with the application, AND a copy of this form must be left with the applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE, HMO COVERAGE OR EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT

GLOBE LIFE INSURANCE COMPANY OF NEW YORK

A New York Stock Company * Home Office: Syracuse, New York

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

According to your application, you intend to terminate existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a policy to be issued by Globe Life Insurance Company of New York. 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 new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this policy. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER OR AGENT:

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) checked below:

_____ 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) _____

(1) Health conditions which you may presently have may be considered pre-existing conditions and 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 regulation provides that in applying a pre-existing condition limitation, a Medicare supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare supplement insurance, Medicare select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy.

(3) If you still wish to terminate your present policy and replace it with new coverage, review the application 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.

****

_____

(Agent's Signature)

Type or print name & address of Agent or Broker:

_____

_____

_____

(Applicant's Signature)

_____

(Date)

MKT0013

GLOBE LIFE INSURANCE COMPANY OF NEW YORK

P.O. Box 3125, Syracuse, New York 13220-3125

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

Your application for the Medicare Supplement insurance policy (certificate) issued by this company indicates that you intended to terminate existing Medicare Supplement insurance coverage, Medicare Select coverage or health maintenance organization (HMO) issued Medicare risk or cost contract and replace it with the coverage applied for with this company. Duplicate Medicare Supplement insurance coverage is unnecessary and you should terminate one of your Medicare Supplement insurance, Medicare Select or HMO contract if more than one such contract is still in force.

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered YES, this form must be dated, signed by the applicant and by the Agent, and submitted with the application, AND a copy of this form must be left with the applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE,
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GLOBE LIFE INSURANCE COMPANY OF NEW YORK

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You should review this new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this policy. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER OR AGENT:

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) checked below:

_____ 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) _____

(1) Health conditions which you may presently have may be considered pre-existing conditions and 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.

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****

_____ (Agent's Signature)

Type or print name & address of Agent or Broker:

_____

_____

_____ (Applicant's Signature)

_____ (Date)

MKT0013

GLOBE LIFE INSURANCE COMPANY OF NEW YORK

P.O. Box 3125, Syracuse, New York 13220-3125

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