The American Home Life Insurance Company

Producer Guide

Effective date: 05/09/2022

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or distribution.

03.21.22

Introduction

Section 1

The American Home Life Insurance Company

Table of contents

Helpful hint: If you'd like to search for a specific term, just press Ctrl+F.

You can always access the latest version of this guide on www.amhlifeco.com.
Content subject to change to ensure compliance with American Home Life Insurance requirements.
To the extent there is any conflict between the descriptions in this guide and the terms of your contract with American Home Life Insurance, the terms of the contract control.

American Home Life History & Values

American Home Life Insurance Company (AHL) was founded in 1909 in Topeka, Kansas under the name Kansas Home Mutual Life Insurance Company. In 1912, the Company merged with American Mutual Life Insurance Company of McPherson, Kansas and adopted its current name – American Home Life Insurance Company – which the Company has operated under for over 100 years. Throughout the last century, American Home Life's mutual corporate structure, conservative investment philosophy, and Midwestern value-oriented culture have enabled AHL to grow and prosper through multiple World Wars, epidemics, and recessions while fulfilling its commitments to its policyholders, agents, and employees.

AHL was founded and operates today as a Mutual insurance company. A mutual insurance company is simply a company that is owned exclusively by its policyholders; it has no shareholders and is not publicly traded on any exchange. This distinction is very important because it means AHL can solely operate in policyholder's long-term interest without having to weigh the effects company decisions may have on shareholder's short-term interests. As a result, AHL is superiorly positioned to navigate its way through unexpected future financial or political events and is ultimately better able to fulfill its obligations to its policyholders both on time and in full when we're needed most.

A long-term and conservative investment management philosophy has always been the foundation of AHL's financial strength and stability. AHL's asset management team deploys capital into the marketplace under a highly customized, conservative investment strategy which prioritizes ongoing, long-term financial solvency above all else. AHL's past and present performance has earned the company a "Stable Outlook" rating from AM Best, the industry's leading ratings agency. AHL's portfolio is currently and will remain well positioned to continue fulfilling its obligations to policyholders now and into the future, regardless of the financial climate of the day.

As a 100+ year old Kansas Company, Midwestern values are deeply rooted into the corporate culture of AHL. Honesty, integrity, courtesy, are qualities we believe our policyholders expect and deserve from AHL when they choose to entrust us with their life insurance needs. We strive to demonstrate these values every day and at every level of our business operation. From the cordial conversation you'll encounter when calling in, to the ease you'll experience when buying our simple, transparent products, we believe these values will be immediately apparent to our policyholders both on the surface, and in the 'fine print.'

Key Terms

Take a minute to review key terms and acronyms below, which are used in this guide or other communications.

AEP	Annual Election Period
amhlifeco.com	The website for American Home Life Insurance Company information: www.amhlifeco.com
CMS	The Centers for Medicare & Medicaid Services, a federal agency within the U.S. Department of Health and Human Services (DHHS) that administers the Medicare program.
Downline agent	A person or entity whose contract connects to one or more uplines; or a licensed-only agent.
Licensed-only agent or LOA	Any licensed insurance agent who is either employed by or under exclusive contract with and upline to sell or refer insurance products for the upline.
MA/MAPD	Medicare Advantage/Medicare Advantage and Prescription Drug
PDP	Medicare Part D, a stand-alone prescription drug plan.
Telephone Consumer Protection Act (TCPA)	A federal consumer privacy statute enacted in 1991. It regulates and restricts the use of automated technology to call mobile phones. The statute applies to outbound telephone calls, including voice messages, prerecorded or artificial voices, SMS text messages and faxes (i.e., telemarketing).
Termination without cause	This Agreement may be terminated for any reason or no reason, at any time by either party, upon written notice to the other party, which notice shall be provided no later than 15 days prior to the termination date.
Upline	A firm, agency, organization or person with downline agents.

Agent Experience

Section 2

The American Home Life Insurance Company

Do business with American Home Life

Agent communications

It's quick and easy to stay in the know, just make sure you have a current email address on file with us with we'll keep you updated about:

- Products
- Training opportunities
- Operations, and more

We send communications to the email you gave us when you first contracted. To start receiving our communications at a new email address, or if you're not getting our communications, you can update your email address on amhlifeco.com (agent side) or by contacting the Agent Services team.

And, you can always access an archive of past communications on amhlifeco.com (agent side).

Do business with American Home Life (continued)

Agent secure website

Our website is located at www.amhlifeco.com. From this homepage you can review general information about our products and services.

The secure agent side of our website is designed to help you manage your business with us. It includes reports specific to your sales, communications, product training, top producers, sales materials, and news specifically for our senior supplemental insurance business. Our electronic applications and rate quote tools are also available from the agent secure website.

Agent secure log-in

Under the Secure Login section you can click on "Agents" and sign in with the User Name and Password you created.

If this is the firsts time you've used our website, click on the "Register Now" button after you click "Agents" to register your account.

If you need assistance logging in to the agent secure site, please contact the Agent Services team at 1-833-504-0334.

- Note: If you ever need to change your password, click "your profile" in the upper right hand corner after you've logged in.

Agency secure log-in

If you're and individual agent who owns an Agency, you'll need to register on the website twice.
Register once for you, and once for your agency.

Member directory

Agent Onboarding, Maintenance, Supplies and Market Support - Hours: Mon -Thu: 7:30 AM-4:00 PM CST Fri: 7:30 AM - 11:00 AM CST
Phone: (833) 504-0334

New Business - Hours: M-F 7:30 AM-7:00 PM CST
Phone: (833) 504-0334 Fax: (833) 380-2777
(only for applications using EFT)
Mail new apps paying by check to:
The American Home Life Insurance Company
P.O. Box 14399
Lexington, KY 40512-9700
Make all checks payable to The American Home Life Insurance Company

Case Management - Hours: M-F 7:30 AM-5:00 PM CST Fax: (855) 447-0391

Policyholder Services - Hours: M-F 8:00 AM-5:00 PM CST (agents) M-F 7:00 AM-7:00 PM CST (policyholders)
Medicare Supplement - Phone: (833) 504-0334 (agents) Phone: (833) 504-0334 (policyholders) Fax: (855) 291-0553
Final Expense - Phone: (800) 259-0468 (agents) Phone: (800) 259-0468 (policyholders) Fax: (833) 526-0522

Make check payable to the appropriate underwriting company Reference policyholder name and policy number on all checks and correspondence.
Mailing Address for **RENEWAL PREMIUMS ONLY**
Medicare Supplement/Final Expense
The American Home Life Insurance Company
PO Box 14109
Lexington, KY 40512-4109

Claims - Hours: M-F 7:00 AM-5:00 PM CST
Medicare Supplement - Phone: (833) 504-0334 (agents) Phone: (833) 504-0334 (policyholders) Fax: (859) 280-3617
The American Home Life Insurance Company
PO Box 14109
Lexington, KY 40512-4109
Final Expense - Phone: (800) 259-0468 (agents) Phone: (800) 259-0468 (policyholders) Fax: (833) 526-0522
The American Home Life Insurance Company
PO Box 534
Brownwood, TX 76804

The Agent Services team

The Agent Service team is focused on your needs as a new or experienced agent/agency. We want to help you grow your business.

The Agent Serivces team can help answer your questions about:

- Product details and benefits
- Placing sales supply orders
- Field Communications
- Navigation and login support for www.amhlifeco.com
- Submitting a new application ising the American Home Life Quote & Enroll tool or using paper

Additional assistance available:

- New application rate quotes
- Drug/formulary lookup
- Checking active appointment status for products and states
- Providing contact information for other departments
- Updating agent email and mailing addresses

Contracting, Licensing and Appointment

Section 3

The American Home Life Insurance Company

The contracting process

Getting Contracted

AmeriLife and its partner affiliates are exclusive distributors of all American Home Life Medicare Supplement and Patriot Series Final Expense Plans. All agents who wish to contract with American Home Life to sell the aforementioned products can contact AmeriLife or their partner affiliates to receive an contracting kit via SuranceBay or AmeriLife's proprietary AgentXcelerator contracting platform.

Just in Time appointment

For all states except Pre-appointment states, we process "Just In Time" (JIT) appointments. This means we submit the appointment agreement to a state Department of Insurance (DOI) once you've submitted your first application in that state.

- We use the date of the first application signature to backdate your appointment.
- We will not be able to backdate your appointment or process the application in the number of days between the application signature and when we receive the application exceed the state allowance for backdating.
- Most states allow 15 days between the application signature and when we receive the application. There are a few exceptions to this.
  - 30 days: Florida, Iowa, Kansas, North Dakota, Texas, Virginia

The contracting process (continued)

Agent background check and review process

As part of the contracting process, we perform standard background investigations/regulatory reviews that include but are not limited to:

- National Criminal Search
- Federal Criminal Search
- County Criminal Search
- Professional License Verification
- Medicare Debarred & Exclusion Lists (OIG, SAM and OFAC)

If the background investigation/regulatory review returns as approved, we'll complete the final steps of the contracting process. If a background investigation/regulatory review does not return as approved, it will be reviewed by our contract review team to decide whether the agent can move forward with the contracting process or if the contract will be declined.

When an applicant is under review, we'll send a Pre-Adverse action letter and a copy of the applicant's background/credit report to the applicant's email address. If no email address is available, the letter and report will be mailed to the applicant. During the review process, the applicant has 10 business days from the date of the letter to provide a response.

If the applicant wishes to dispute the accuracy of the information in the background report, the application should contact Application Insight, the consumer reporting agency that provided the report, at 1-800-771-7703 x 2048.

We complete the final steps

If the applicant is approved, we'll send a welcome letter to the agent/agency and their upline.

If the applicant is not approved, we'll send a decline letter to the agent/agency and their upline.

If your application is not approved, you can re-apply any time you feel your background or credit status has changed and would like us to start a new application and review process.

Contract and demographic changes

Demographic Changes

If you want to change the name of your agent record, we'll need a copy of your license showing your new name.

If your agency name is changing, you'll need to send us a detailed request and a copy of your agency license showing the new agency name.

If your agency Tax ID is changing, it is considered a hierarchy change and we'll have to issue your agency a new writing number.

Checking on updated appointment status

An agent or their upline may use our website www.amhlifeco.com to see updates made to an agent's onboarding status and appointments, which will appear 24 hours after being completed.

Agent termination information

Agent terminations

All agent/agency appointment terminations are reviewed by our business leadership. In order to comply with state timing requirements, appointment terminations are processed in our system on the same day we send the termination letter to the agent. Typically, the effective date of the termination is 15 days after the notice is sent. The effective date may vary depending on the reason for the termination.

Compensation

Section 4

The American Home Life Insurance Company

Compensation overview

"Compensation" means first year, renewal and override commissions and other forms of remuneration earned by an agent in connection with the sale of our Senior Supplemental insurance products.

How we pay

The compensation year is January 1 through December 31.

EFT is required. You'll get paid faster. We initiate all commission payments on the nearest commission processing day after the initial draft date of the policy.

For Medicare Supplement, we process commissions twice a week (Wednesdays and Saturdays), and it may take up to 2 business days to get to your account.

For Final Expense, we pay daily, and it may take up to 2 business days to get to your account.

We EFT to the information we have on record.

Based on your contract, you have 30 days to contest payment and calculations on a commission statement.

Commission

Marketing General Agents and General Agents are paid a commission for each member they enroll in accordance with their contract.

Commissions for licensed-only agent (LOA) sales pays directly to their upline.

We calculate commissions on the commission cycle after the premium is applied to the policy. When a policyholder pay modal premium, our system calculates commission payment based on your commission schedule and will disburse on the next available commission cycle.

Initial and renewal sales

Initial Sales

- "Initial sale" means an applicant is enrolling in a product for the first time.

We pay Initial Sale commissions in accordance with the year 1 commission rate on the corresponding schedule.

Renewal Sales

- "Renewal sale" means any premium paid after the first payment. (This could be monthly, quarterly, semi-annually or annually.)

We pay renewal sale commissions based on the age of the policy years 2 and beyond.

Advance commission, chargebacks and unearned commission

Advance commissions

- You must be set up for advance commissions prior to the signature date on the application.
- If your EFT transaction is rejected twice, the commissions advance will charge back to your agent commissions account and change from advance to paid as earned.
- If your policyholder is paying their premium by direct bill, that policy is not eligible for advance commissions.

Chargebacks

If a policy is cancelled, withdrawn or not taken within the first 30 days of policy receipt, 100% of the premium will be refunded to the applicant and 100% of commissions will charge back to the agent.

If a policy is cancelled after 30 days, the premium and commissions will be prorated.

If a policy is rescinded for material misrepresentation within the two year contestability period, commissions will charge back to the agent.

Unearned commission

If you're advanced commission for a policy and the policy is cancelled, the advance will be considered unearned commission. Unearned commission will charge back to your agent commission account. If a chargeback causes your agent commission account balance to be negative, you won't receive commission payments until commissions from new submitted business bring your agent commission positive again.

1099 forms

1099 forms

Commissions are reported via the Internal Revenue Service (IRS) 1099 process. 1099 MISC forms are postmarked to all eligible recipients by January 31 of a given year and mailed to the payee address on file.

A 1099 MISC form will only generate to an agent if annual earnings are $600 or above.

If earnings are less than $600, agents can obtain earning totals by visiting our secure agent website and viewing their commission reports. Note: The last statement date in December pays in January, so those earnings count toward the following tax year. (Example: A 12/22/16 statement date will count toward 20217 taxes, as payment is not generated and sent until after 1/1/17.)

- We mail 1099s on January 31 for the prior tax year
- If you need another copy of your 1099, we can fax or mail you a duplicate
- We can't send your 1099 to you email address.
- If you need to change information on your 1099, please call the Commissions department.

How termination affects compensation

How termination affects compensation

If you are terminated, but still in good standing, you will continue to receive renewal commissions according to your commission schedule.

If you are terminated for cause, we will cancel your compensation payments in accordance with your contract.

Recovery process for terminated agents with debit balances

If you are terminated and have a debit balance on your agent commission account, we will pursue collection of debt.

Marketing Materials

Section 5

The American Home Life Insurance Company

How to order your sales supplies

It's easy for you to order the supplies you need to sell our products.

Once you've logged in to the agent side of amhlifeco.com, go to Tools, the Order Supplies/Download Forms.

Order Full Kits or Individual Pieces

- **Full Kits - Electronic vs Paper Enrollment Kits - IMPORTANT - if you plan to enroll your clients via e-app (not paper) please only order the electronic kits. These kits will exclude unnecessary paper documentation (apps) and these orders will be fulfilled much more quickly than paper kits.**

- **Individual Pieces** - Do you have your own agency branded folders and only need certain pieces such as a brochure? If so, only order the individual pieces you need. These orders will be fulfilled much more quickly than full kits.

Verify Your Kit Corresponds to Your State of Operation

Using our logo

Looking to use the American Home Life logo on your advertising?

It's a simple process. You just need to complete a quick form to request permission and get approval first. Once approved, you'll receive the logo and instructions on how to use it.

- Note: To request Logo use, please go to the agent zone, and find our list of "Advertisement Check List" to make sure your advertisement is in compliance. Next, you can fill out "Advertising Review Submission Form" and submit the completed form along with a copy of all advertisements you wish to use to md@amhomelife.com. Once we have received all of the documents, we will review the advertisements and approve, recommend changes, or disapprove within 5 business days.

Submitting Business

Section 6

The American Home Life Insurance Company

Before completing an application

Before completing an application

You should review the policy specifics of each policy and ensure that your applicant understands the costs and benefits.

Always take enough time with your applicant to assure they fully understand all application questions and terminology.

The initial premium draft can only be processed on the policy issue or effective date. If you don't select your applicant's preference on the application, we will draft the initial premium on the issue date of the policy.

Power of attorney

If the application is underwritten, it must have the applicant's signature. A Power of Attorney may only sign an application in place of the applicant on Medicare Supplement guaranteed issue or Open Enrollment applications.

- Note: An application signed by an Attorney-in-fact (Power of Attorney) must follow this format: "John Smith, Attorney-in-fact, for Mary Smith" or "Mary Smith by John Smith, Attorney-in-fact"

Before completing a Medicare Supplement application

Medicare Supplement applications

Review and clarify the difference between guaranteed issue, Open Enrollment and underwritten applications.

Medicare Supplement guaranteed issue

Guaranteed issue, or trial rights, are listed in the Choosing a Medigap Policy Booklet produced by CMS.

Guaranteed issue is 63 days after loss of coverage. Submit the application within 63 days of the applicant's termination date from prior insurance.

Proof of creditable coverage is required in all guarantee issue events.

- You can post-date a guaranteed issue effective date. It can be 90 days past the signature date.
- Guaranteed issue applications must be submitted with the required proof of creditable coverage documentation.
- Federal and State guidelines outline eligibility for guaranteed issue applications. Please consult the Department of Insurance for qualifying events in your applicant's state.
- Plans G and N are not available for guaranteed issue applications in most states.
- All Eligibility questions must be completed. Dates and prior carrier information are required on all guaranteed issue applications.
- If prior coverage is listed, a replacement form is required
- Health questions should not be answered.
- Guaranteed Issue policies are issued with preferred (non-smoker) rates. State exceptions may apply.

12 month trial right situations:

- When your applicant first became eligible for benefits under Part B (or Part A in some states) of Medicare at age 65 or older, they enrolled in a Medicare Advantage plan and within the first year of joining, decided they wanted to switch to Original Medicare. – applicant is eligible for guaranteed issue.
- When your applicant was enrolled in a Medicare Supplement policy and chose to drop that policy to join a Medicare Advantage plan for the first time, and within the first year of joining, decided they wanted to switch back. -applicant is eligible for guaranteed issue for the same policy they had before if the same insurance company sells it. If their former policy isn't available, they can buy Plan A, B, C, F, K or L from any insurance company in their state.

Before Completing a Medicare Supplement Application (continued)

Guaranteed issue- loss of Group Medical Coverage

We require a copy of the disenrollment (creditable coverage) letter with:

- Applicant name(s)
- Applicant address
- Date of termination

Guaranteed issue – loss of Medicare Advantage (MA)

For a no fault disenrollment, such as the MA leaving the area, we require:

- A completed Replacement form
- A copy of the notification from the MA with:
  - Reason for disenrollment
  - The disenrollment date
  - Applicant name(s)
  - Applicant address

For the applicant leaving the area, we require:

- A completed Replacement form
- Documentation indicating prior address

OR

- A copy of the applicant's MA ID card
- A copy of the notification from the MA with:
  - Reason for disenrollment
  - The disenrollment date
  - Applicant name(s)
  - Applicant address

For Misrepresentation, we require:

- A completed Replacement form
- A copy of the final judgment on the filed grievance

Before Completing a Medicare Supplement Application (continued)

Medicare Supplement Open Enrollment

Medicare Supplement Open Enrollment is a one-time (in most instances) period when an individual can purchase any Medicare Supplement plan offered in their resident state. It begins 180 days before the policyholders Part B effective date (except Wisconsin which is 90 days before) and ends 180 days after the Part B effective date. If the policyholder takes on a Medicare disability they will receive a second Open Enrollment when they turn 65.

Open Enrollment begins on the 1st of the month in which the applicant becomes 65 and /or enrolls in Medicare Part B for the first time.

- You can post-date an open enrollment effective date. It can be 180 days past the signature date (except West Virginia which is 90 days).
- Health questions should not be answered
- Open Enrollment policies are issued with preferred (non-smoker) rates. State exceptions may apply.
  Medicare Supplement underwritten applications

Medicare Supplement underwritten appplications

Any applications that don't meet the guaranteed issue or Open Enrollment qualifications.

Underage Disability Insurance

Available only in states where we have filed and approved underage rates. For age, state, plan availability and application type (guaranteed issue, Open Enrollment or underwritten), please consult the Outline of Coverage for your applicant's state.

Anniversary and birthday rules

Missouri anniversary rule:

- 60 day enrollment period, beginning 30 days prior to your applicant's policy anniversary date.
- Your applicant must choose the same plan as their current plan (F to F, G to G).
    - We need proof of current Medicare Supplement Coverage that includes plan description and effective dates, such as an ID card or Schedule Page.

Illinois birthday rule:

Illinois provides a special Open Enrollment period for individuals between 65 and 75 years old who are currently enrolled in Medicare supplement plans.

- 45 day enrollment period, beginning on your applicant's birthday.
- Application must be signed (application signature date) within 45 day Open Enrollment period.
- Effective date must fall on birthday or up to 90 days after birthday.
- The new plan must be from the same underwriting company as the existing plan.
    - Note: if the existing plan's underwriting company is now closed, the birthday rule would not apply. The new application would need to be underwritten.
- Plan benefits must be of equal or lesser value to current plan.
    - We need proof of current Medicare Supplement coverage that includes plan description and effective dates, such as an ID card or Schedule Page.

Anniversary and birthday rules (continued)

Idaho birthday rule: (effective 3/1/2022)

Idaho provides a special Open Enrollment period for individuals currently enrolled in Medicare supplement plans.

- 63 day enrollment period, beginning on your applicant's birthday.
- Application must be signed (application signature date) within 63 day Open Enrollment period.
- Effective date must fall on birthday or up to 90 days after birthday.
- Plan benefits must be of equal or lesser value to current plan.
    - We need proof of current Medicare Supplement coverage that includes plan description and effective dates, such as an ID card or Schedule Page.

Nevada birthday rule:

Nevada provides a special Open Enrollment period for individuals currently enrolled in Medicare supplement plans.

- 60 day enrollment period, beginning on first day of your applicant's birthday month.
- Application must be signed (application signature date) within 60 day Open Enrollment period.
- Effective date must fall on birthday or up to 90 days after birthday.
- Plan benefits must be of equal or lesser value to current plan.
    - We need proof of current Medicare Supplement coverage that includes plan description and effective dates, such as an ID card or Schedule Page.

Completing the application

Completing the application

You can complete and submit online applications for most of our products with the American Home Life Quote & Enroll tool. Go to amhlifeco.com, agent side home page/E-App tool is the fastest way to submit new applications. It's easy and time to go paperless.

- One login – from amhlifeco.com
- Multi-device capability – runs on laptops, desktops, and tablets
- Security question and electronic signature options
- Applicant specific guidance – based on answers to questions
- In-good order applications – key information (accurate data) required
- Submit in real time – processing begins immediately
- Rapid visibility to submitted applications – an online report in 30 minutes
- Empty your briefcase and trunk – no more loads of forms and paper

In addition to E-App, completed paper applications may be submitted by mail or fax.

Paper applications must be submitted within 30 days of the applications signature date.

If your applicant is paying by check, the application and check must be submitted together by mail.

- Note: Do not fax the application and mail the check

Completing the application (continued)

Complete all fields on the application – and other required forms

Applications must be signed by the primary insured (policy owner) and the spouse/domestic partner, if applicable

- Power of Attorney signature is not acceptable on Medicare Supplement guaranteed issue or Open Enrollment applications

CMS is removing Social Security numbers from all Medicare cards. The new cards will have a Medicare Beneficiary Identifier (MBI) that replaces the Health Insurance Claim Number (HICN)

- The MBI still has 11 characters, but doesn't use the letters S, L, O, I, B, and Z.
- The character grouping for the MBI (1EX2-EX3-EX45) is visually different from the HICN.
- Use whichever of these numbers your applicant has if the application has a field for the Medicare card number.

If you make corrections to the application before the application is submitted, you applicant must strike over and initial the correction. Don't use White-Out.

Make sure you select the coverage type, plans and optional coverage as well as the benefit amount your applicant wants to apply for.

If the product you're selling includes optional riders, please indicate any that your applicant does not want to apply for with N/A.

You must select the premium mode and payment method on the application.

If your applicant isn't going to pay annually, use the online rate quote tool or the modal factors in the outline of coverage or the rate guide to make sure you calculate the correct premium.

All health questions must be answered for underwritten plans.

A completed HIPAA form is required with all application submissions.

Your Agent Writing Number and signature are required before the application is submitted.

Completing the application (continued)

Choosing an effective date

All applications must contain a requested effective date.

Effective dates must be on or after the signature date on the application. All dates are available with the exception of the 29th, 30th, or 31st of each month.

All underwritten applications can be submitted 90 days prior to the effective date.

Review the signature date

Signature dates can't be:

- After we receive the application
- More than 30 days before we receive the application
- After the effective date

Application fees

If a product has an application fee, it will be detailed in the outline of coverage or the rate guide.

Completing the application (continued)

Initial draft date

Initial premium for electronic funds transfer will either be drafted on the day on issuance or on the effective date of the policy. If you don't select which date you'd prefer for the initial premium draft, EFT will draft on the issue date.

If the first attempt to draft the initial premium is not successful, we will make a second attempt to draft the initial premium. If the second attempt to draft the initial premium is not successful, the policy will be changed to quarterly direct bill. The policyholder will need to pay the premium in full before their policy is active. If we don't receive payment within 45 days, the policy will lapse. If the policy has lapsed, a new application and telephone interview (if applicable) are required.

Know your bill date

If your applicant wants the bill date for their policy to be different than the Initial draft date, they may request a subsequent bill date on the application at the time of submission. The bill date shouldn't be more than 15 days after the policy effective date. If it is, our system with draft the policyholder's account twice the first to make sure the policy doesn't lapse before the next bill date.

Your applicant can't request a bill date on the 29th, 30th, or 31st of the month.

- All bill dates requested for the 29th will be drafted on the 28th of the month.
- All bill dates requested for the 30th or 31st will be drafted on the 1st of the following month.

Payment methods

Payment methods

Requirement for EFT Payments:

- The EFT section of the application must be completed, signed and dated.
- If the owner of the bank account is someone other than your applicant, the bank account owner must sign where indicated on the application.
- All modes of premium may be drafted.

Requirement for direct bill payments:

- The payment should be submitted at the same time as the application.
- If not, the policy will be issued and an invoice will be sent to the policyholder.
- The policyholder will need to submit the initial payment within 30 days of the policy issue date.
- No commissions and no claims are processed until the initial payment is received.

We don't accept monthly direct bill for Final Expense premiums.

Net billing

If there is a shortage on the initial payment we'll send a bill notice to both the applicant and the agent.

If we don't receive the payment within 20 days from the issue date, we'll send a 2nd bill notice to both the applicant and the agent.

If we don't receive the payment after 30 days from the issue date, we'll close the application. Any funds we received up to that point will be refunded to the account holder in the next billing cycle. If the applicant still wants a policy, a new application is required.

Telephone interview

Telephone interview

We no longer require Point of Sale telephone interviews for our applications.

We may require a clarifying telephone interview on underwritten applications if an underwriter needs additional information.

Your applicant needs to consent to the prescription check/telephone interview.

Please ensure that your applicant knows the name of the underwriting company on the application and signs the HIPAA form before you submit the application.

Underwriting

Underwriting

Applications are underwritten up until the time the policy is issued and first premium paid. If a declinable health condition is discovered between the time the application is taken and the time the policy is issued, the application will be declinable.

Prescription checks are required on all underwritten business.

- Note: We no longer require Point of Sale telephone interviews on underwritten business. We may require a clarifying telephone interview after an underwriter reviews the application.

Applications must include all pages of the application, HIPAA form, replacement form (if applicable) and any state required forms.

Power of Attorney signatures are not acceptable on any underwritten applications.

All health questions on underwritten applications must be answered completely before the application is submitted.

- Any "Yes" answer to a health question will automatically disqualify your applicant. You should not submit this application.
- Note: For Final Expense, all health questions must be completed up until a "Yes" answer is provided, if any. A "Yes" answer may not automati cally disqualify your applicant. They may qualify for a different level of plan.

The health history should include a complete list of all your applicant's medications and the diagnosis for which they are prescribed. Refer to the drug list information which can be found on the Agent Zone for any unacceptable medications.

- Applications which include any of the unacceptable medications should not be submitted for consideration.

The physician information should include all the physicians your applicant has seen within the past 24 months, including primary care and any specialists. This section must include the physician's name, specialty and reason for the visit (diagnosis).

- If additional space is needed to list your applicant's medications or physician information, please use a separate piece of paper and attach it to the application.

Closed and declined applications

Reasons we'll close an application

- The incorrect documents were submitted.
- Guaranteed issue applications were submitted without all required documents.
- Applicant contact information is incorrect/missing and we haven't been able to contact the applicant.
- Anyone other than the applicant supplies the answers to the questions and signs the application. Power of Attorney (POA) signing is not acceptable. (Exception: Open Enrollment/Guaranteed issue only – Attorney-In-Fact signing on behalf of applicant.)
- The applicant did not know they applied for insurance.
- The applicant does not consent to a prescription/medical history check, or does not complete a clarifying telephone interview.
  - Note: We'll attempt to call the applicant 2 times for a clarifying telephone interview. If we haven't been able to reach the applicant after those attempts, we'll send the applicant a letter letting them know they need to contact us within 10 days of the date of the letter to schedule an interview. If the applicant does not contact us we'll close their application and a new application will be required.
- Anyone other than the applicant completes the telephone interview.
- During the telephone interview, we discover that the agent who signed the application did not speak with the applicant.
- Any health questions are unanswered or are answered "Yes".
  - Note: For Final Expense, a "Yes" answer may not automatically disqualify your applicant. They may qualify for a different level of plan.
- If the application was submitted with a check from a third-party payor that has no family (spouse/partner, child, etc.) or business relationship (business owner, employee or retiree of the business).
- We receive the application at the home office more than 30 days after the applicant's signature date.
- Applicant is not a legal U.S. resident.
- Multiple options were selected within the non-forfeiture options of the Final Expense application. (See Final Expense brochure for further details.)

Closed and declined applications (continued)

Incomplete or unreadable applications

If the document is incomplete or illegible, the application will be closed and a clear and complete copy will need to be resubmitted.

- Illegible applications need to be submitted in a way that they're readable.
- Incomplete applications have to be completely resubmitted.

Don't use Wite-Out

An application submitted with Wite-Out on any page is automatically closed. When you resubmit, new signature dates are required.

Declined applications

Common reasons for Medicare Supplement application decline:

- Any type of further evaluation, diagnostic testing or surgery that has not been performed, or where test results are pending.
- Any condition listed under Question 3 of the Health questions section.
- Macular Degeneration (wed) requiring injections within the last 12 months.
- Atrial Fibrillation currently being treated with any medication.
- Diabetes with heart or artery blockage at any time.
- Diabetes with any history of aneurysm, stroke or Transient Ischemic Attack (TIA)
- History of prostate cancer with a detectable Prostate Antigen (PSA) reading.
- Osteoporosis with any type of fracture, including fracture due to accidents.
- Lung or respiratory disorders: use of oxygen or a nebulizer within the past 24 months (including hospital/in home use).
- Lung or respiratory disorder with tobacco use in the past 12 months.
- Prescribed medications for conditions listed on the application. We consider this treatment for the condition.

Policyholder Experience

Section 7

The American Home Life Insurance Company

Policyholder services

Sending documentation to policyholder services

We can't accept certain types of information via email. You'll need to mail or fax us the following types of information:

- Death certificates
- Bank information
- Anything that includes Protected health Information (PHI)

Free look period

The "free look period" is 30 days from the time the policyholder receives the policy. If they selected the option for E-delivery the 30 day free look period starts once the E-policy is opened.

A written request is needed to cancel within the free look period. The easiest and most accurate way to fulfill this requirement is to write "Cancel" on the policy and mail it back to us.

If your applicant indicates they wish to withdraw or cancel the application:

- If the application is in pending status, you or your applicant can call the New Business department, at 1-833-504-0334 to withdraw the application.
- If the application status is already active, you or your policyholder can notify Policyholder Services to terminate the policy.

Changing Accident & Health policy benefit amounts

If your policyholder would like to increase the benefit amount of their Accident & Health policy, they will need to submit a new application.

If your policyholder would like to decrease the benefit amount of their Accident & Health policy, they do not need to submit a new application.

Final Expense benefit amounts

Changing Final Expense benefit (face) amounts

Within 30 days of the application signature date:

- If your policyholder wants to increase or decrease the benefit amount:
  - Contact us (New Business) with the change request
  - We'll reach out to Landmark to initiate the change

If the request is greater than 30 days from the application signature date:

- If your policyholder wants to increase the benefit amount:
  - Complete a new application for the additional benefit amount
  - Your applicant's current age will apply
  - The new policy must meet the minimum benefit amount
  - The combined policies can't exceed the maximum benefit level
  - The two year contestability period restarts from the new policy effective date

- If your policyholder wants to decrease the benefit amount:
  - Complete a new application for the total of the desired benefit amount
  - Your applicant's current age will apply
  - We'll send a request to Landmark to cancel the existing policy and issue a new policy for the new benefit amount
  - They'll refund any cash value from the cancelled policy to the policyholder
  - The two year contestability period restarts from the new policy effective date

Changing policy effective and bill dates

Changing an effective date

If your policyholder wants to change their policy effective date, we'll review the change request. You or your policyholder will need to send us a written request stating the change of effective date and the reason for the change.

- All change requests are subject to approval.
- The request must be submitted within the first 60 days of the policy effective date.
- If the change request is approved, the original policy will be terminated and a new policy will be issued with the new effective date.
- Any premium payments collected will be applied to the new policy.
- If the reason for the request is because they had prior Medicare Supplement coverage, we need to receive documentation showing the termination date of the prior coverage.

Please note: If an effective date is changed after 30 days, the policyholder's two year contestability period restarts on the new effective date.

For Final Expense, the request must be submitted within 30 days of the application signature date:

- Contact us (New Business) to request the change.
- If the change request is approved, we will initiate the change with Landmark.

Changing a Bill Date

If your policyholder wants to change their bill date after their policy is active, they may contact our Policyholder Services department. The new bill date shouldn't be more than 15 days after the current bill date. If it is, our system will draft the policyholder's account twice the next month to make sure the policy doesn't lapse before the next bill date.

Policy reinstatement

Medicare Supplement

There will be no gap in coverage if payment is made within the state allowed timeframe

If the policyholder does not make a payment during the state allowed timeframe, a reinstatement form may be used up to 90 days from the paid to date.

After the state allowed timeframe:

- A reinstatement form must be completed and signed
- Reinstatement will be reviewed and considered

Our premium payment should be submitted with reinstatement application (if reinstatement is denied, the premium will be refunded).

Policies reinstated using a reinstatement form will have a gap in coverage (from paid to date to date of reinstatement).

After 90 days a new application is required.

Final Expense

All back premiums must be paid in order to reinstate the policy within 60 days of the paid to date.

No reinstatement form is required.

Canceling and refunds

Canceling a policy

If your policyholder wants to cancel their policy, you or your policyholder will need to send us a written request with your policyholder's name, policy number, signature and the date your policyholder wants cancellation to take effect.

- Note: If we've paid claims for service dated after the requested cancellation date, we will set the policy cancellation date for the month after the date of the claimed service.

- For a Medicare Supplement cancellation, your policy holder may be able to call us instead of sending a written request.
- In order to backdate a Medicare Supplement cancellation, your policyholder needs to send us proof of prior Medicare Supplement coverage showing effective dates.
- If your policy holder is moving to another carrier, they must contact that carrier. We cannot cancel on their behalf.

Refund guidelines

Before we can issue a refund for premiums, any pending payment must clear. Refunds are always mailed in the form of a paper check. Even if your policyholder is set up for EFT, we are not able to deposit money back into a bank account.

- Allow 15 days for an EFT payment to clear (this is in place so last premium payment can clear first)
- Allow 20 days for a paper check or money order to clear

Explanation of benefits (EOB)

EOB's are available weekly on our website www.amhlifeco.com and are mailed quarterly to our policyholders.

Your policyholder can opt out of paper delivery via the secure policyholder website.

We complete a medical review before processing claims when our policyholder submits a claim where the dates(s) of service are within two years of the effective date of the policy.

Policyholder claims

Medicare supplement claims

All Medicare supplement claims must be submitted through Medicare; we cannot process payment from balance due statements.

Liability: Our liability is based on Medicare's approved and eligible charges. If Medicare has no coverage, then the secondary plan has no liability.

Appeals: If our policyholder does not agree with the way Medicare processed a claim, they need to appeal directly to Medicare.

Plans G & N: There specific plan types have certain patient responsibility components that are not covered as part of the Medicare Supplement plan.

If your policyholder has a name change, they'll need to change their name with Medicare first and then call us to change it. We won't update our records unless they match Medicare. When the records don't match, it will cause an error with crossover claims.

If your policyholder submits a claim that is missing their Medicare Beneficiary Identifier (MBI) number, crossover claims with Medicare will not be accepted.

Life claims

Notice of a life claim can be made by submitting a death certificate of calling in to report the death. We'll then send a packet the beneficiary to start the process.

If the death occurs within the two year contestable period, we will conduct a claims investigation into the insured's health condition.

Policy will be rescinded for material misrepresentation pursuant to state law.

Online tools for policyholders

Member secure website

Our website is located at www.amhilfeco.com. From this homepage your policyholders can review general information about our products and services.

All Medicare Supplement and Patriot Series Final Expense Policyholders can login (after initial sign-up) to the secure member side of our website.

Once they've logged in, your policyholder can:

- view policy details and claims
- access member discounts
- request duplicate ID cards and policy pages
- update contact and bank information
- send department specific request

Member secure login

Under the Secure Login section your policyholder can click on "Members" and sign in with the User Name and Password they created.

If this is the first time they've used our website, they can simply click on the "Register Now" button to register their account. The sign-up process is quick and simple, but just in case technical assistance is required, we have a dedicated web assistance team that provides website related technical assistance.

Online tools for policyholders

Correspondence preference

Once the policyholder is logged in to the secure website, they can click on “My Notifications” on the left side of the screen.

Next they will click on the link on the right side that says Correspondence/Alert Preference and the click on Correspondence Preference.

Once there just click on the Receive Electronic correspondence button to receive EOB’s through the email they have set up on file.

ID cards

ID cards are available for Medicare Supplement policies only.

A temporary Medicare Supplement ID card is available to view, download, or print from our website.

All other products don’t require an ID card since the benefits are paid to the policyholder. For some of our products, we offer the ability to print a card that includes the policy number and basic claim submission information.

The American Home Life Insurance Company