

NEW ERA LIFE INSURANCE



U-65 ENROLLMENT USER GUIDE

Main Agent Dashboard

77084

New App >>

Welcome: SONJA HOMEOFFICE

Select Language ▾

5



Completed Apps

To enroll a new applicant enter the applicant's zip code and click the "New App >>" button. You will then be directed to the **Plan Selection Page**.

115



Leads & Quotes

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Plan Selection

Plan Selection

Household Members

Payment

Summary

1

Location & Effective Date

County

Harris

Zip Code

77084

Change

Choose Effective Date

2

Billing Method

Individual Bill

Group Bill

EFT

CC

Note: Click the radio button to change/reselect the billing method.

Employee / Member ID

Affiliation Code

Plan Premiums

Monthly Premium

\$0.00

Application Fee(s)

\$0.00

3

Applicants

U-65 UW Guide

U-65 Group UW Guide

MEDICARE UW Guide

Birth Date

Gender

Relationship

Tobacco User?

Est Points

DOB

Male

Female

self

+ Add Another Person

4

Choose Plan

+ Health Saver Plus Gold (Indemnity Benefit Coverage)

+ Medicare Supplement

+ Enhanced 24 Hour Accident Expense Insurance Plan

+ Critical Illness Insurance

+ Dental Choice Plus

+ GAP Insurance (Expense Incurred)

① Under the “Location & Effective Date” box - Notice that the County is populated based upon the Zip Code entered on The Main Agent Dashboard.

Plan Selection

Plan Selection

Household Members

Payment

Summary

① Location & Effective Date

County Zip Code [Change](#)

 **Choose Effective Date**

② Billing Method

☒ Individual Bill ☐ Group Bill
☒ EFT ☐ CC

Note: Click the radio button to change/reselect the billing method.

Employee / Member ID Affiliation Code

Plan Premiums

Monthly Premium **\$0.00**

Application Fee(s) \$0.00

③ Applicants

[U-65 UW Guide](#) [U-65 Group UW Guide](#) [MEDICARE UW Guide](#)

Birth Date Gender ☐ Male ☐ Female
Relationship Tobacco User? ☐ Est Points

[+ Add Another Person](#)

④ Choose Plan

+ Health Saver Plus Gold (Indemnity Benefit Coverage)

+ Medicare Supplement

+ Enhanced 24 Hour Accident Expense Insurance Plan

+ Critical Illness Insurance

+ Dental Choice Plus

+ GAP Insurance (Expense Incurred)

① Effective Date automatically defaults for all products. If you wish to select an alternate effective date, Click **Choose Effective Date** and choose the alternate date desired and click **Save Date**.

Plan Selection

Plan Selection

Household Members

Payment

Summary

1

Location & Effective Date

County

Zip Code

Harris

77084

Change

Choose Effective Date

2

Billing Method

Individual Bill

Group Bill

EFT

CC

Note: Click the radio button to change/reselect the billing method.

Employee / Member ID

Affiliation Code

Plan Premiums

Monthly Premium

\$0.00

Application Fee(s)

\$0.00

3

Applicants

U-65 UW Guide

U-65 Group UW Guide

MEDICARE UW Guide

Birth Date

Gender

Relationship

Tobacco User?

Est Points

DOB

Male

Female

self

+ Add Another Person

4

Choose Plan

+ Health Saver Plus Gold (Indemnity Benefit Coverage)

+ Medicare Supplement

+ Enhanced 24 Hour Accident Expense Insurance Plan

+ Critical Illness Insurance

+ Dental Choice Plus

+ GAP Insurance (Expense Incurred)

② Billing Method:

To select the billing method type, click on "Individual Bill" or "Group Bill". Then, select "EFT" or "CC".

note

Billing Method:
Individual Bill and EFT will automatically default.

Plan Selection

② Billing Method – Group Bill:

Click the Group Bill option and the **Group Selection** box appears. Here you can search by the Group ID or Group name.

The screenshot shows the 'Plan Selection' interface with several sections and annotations:

- Plan Selection Header:** Includes 'Plan Selection' and 'Summary' tabs.
- ① Location & Effective:** Contains fields for 'County' (Harris), 'Zip Code' (77084), and 'Choose Effective Date'.
- ② Billing Method:** Contains radio buttons for 'Individual Bill' and 'Group Bill' (selected). A note states: 'Note: Click the radio button to change/reselect the billing method.' Below are fields for 'Group Name', 'Group ID', 'Employee / Member ID', and 'Affiliation Code'.
- Group Selection Modal:** A red-bordered box highlights a modal titled 'Group Selection'. It has a 'Search By:' dropdown set to 'Group ID' and a list of group IDs: GBN013939, GBN014053, GBN013804, GBN013808, GBN013677, and GBN013886 (highlighted in blue).
- ④ Choose Plan:** A list of plan options with plus icons: 'Health Choice Select (Indemnity Health Coverage)', 'Health Saver Plus III (Indemnity Health Coverage)', 'Health Saver Plus Gold (Indemnity Benefit Coverage)', 'Medicare Supplement', 'Enhanced 24 Hour Accident Expense Insurance Plan', and 'Critical Illness Insurance'.
- Plan Premiums:** A section at the bottom showing 'Monthly Premium' as \$0.00 and 'Application Fee(s)' as \$0.00.

Plan Selection

The screenshot shows the 'Group Selection' dialog box with 'Search By:' set to 'Group ID' and the value 'GBN013677'. The 'Save' button is highlighted with a red box. A yellow callout box points to the 'Save' button with the text: '② **Billing Method– Group ID:** Select the group ID number and click the **save** button.'

Below the dialog box, the 'Billing Method' section shows 'Individual Bill' and 'Group Bill' radio buttons. The 'Group Bill' option is selected. A note states: 'Note: Click the radio button to change/reselect the billing method.' Below this, there are input fields for 'Group Name', 'Group ID', 'Employee / Member ID', and 'Affiliation Code'.

At the bottom, the 'Plan Premiums' section shows a table with columns for 'Monthly Premium' and 'Application Fee(s)'. The 'Monthly Premium' for the selected plan is '\$0.00'.

Plan Selection

Plan Selection

Household Members

Payment

Summary

1 Location & Effective Date

County

Harris

Zip Code

77084

Change

Choose Effective Date

2 Billing Method

Individual Bill

Group Bill

Note: Click the radio button to change/reselect the billing method.

Group Name

301 Holdings

Group ID

GBN013677

Employee / Member ID

Affiliation Code

NA

Plan Premiums

Monthly Premium

\$0.00

3 Applicants

U-65 UW Guide

U-65 Group UW Guide

MEDICARE UW Guide

Birth Date

DOB

Gender

Male

Female

Relationship

self

Tobacco User?

Est Points

+ Add Another Person

4 Choose Plan

+ Health Choice Select (Indemnity Health Coverage)

+ Health Saver Plus III (Indemnity Health Coverage)

+ Health Saver Plus Gold (Indemnity Benefit Coverage)

+ Medicare Supplement

+ Enhanced 24 Hour Accident Expense Insurance Plan

+ Critical Illness Insurance

② Billing Method -

Group Bill:

Once the Group ID or Group name is selected, the information is populated in the **Billing Method** section.

Enter the "Employee/ Member ID" and "Affiliation Code" before proceeding with the Enrollment.

Plan Selection

Plan Selection

Household Members

Payment

Summary

1 Location & Effective Date

County

Harris

Zip Code

77084

Change

Choose Effective Date

2 Billing Method

Individual Bill

Group Bill

EFT

CC

Note: Click the radio button to change/reselect the billing method.

Employee / Member ID

Affiliation Code

Plan Premiums

Monthly Premium	\$0.00
Application Fee(s)	\$0.00
Total Initial Premium (including fees)	\$0.00

3 Applicants

U-65 UW Guide

U-65 Group UW Guide

MEDICARE UW Guide

Birth Date

Gender

Relationship

Tobacco User?

Est Points

04/04/1970

Male

Female

self

Add Another Person

4 Choose Plan

Health Saver Plus Gold (Indemnity Benefit Coverage)

Medicare Supplement

Enhanced 24 Hour Accident Expense Insurance Plan

Critical Illness Insurance

Dental Choice Plus

GAP Insurance (Expense Incurred)

The “Agent Notes” button will show on all screens and allows for notes to be added throughout the Application Process.

Click the “Agent Notes” button for the feature to open a free-form textbox for note entry.

Agent Notes

Plan Selection

Plan Selection

Household Members

Payment

Summary

1 Location & Effective Date

County

Zip Code

Harris

77084

Change

Choose Effective Date

2 Billing Method

Individual Bill

Group Bill

EFT

CC

Note: Click the radio button to change/reselect the billing method.

Employee / Member ID

Affiliation Code

Plan Premiums

3 Applicants

U-65 UW Guide

U-65 Group UW Guide

MEDICARE UW Guide

Birth Date

Gender

Relationship

Tobacco User?

Est Points

04/04/1970

Male

Female

self

+ Add Another Person

4 Choose Plan

+ Health Saver Plus Gold (Indemnity Benefit Coverage)

+ Medicare Supplement

+ Enhanced 24 Hour Accident Expense Insurance Plan

+ Critical Illness Insurance

note ⚡

The **U-65 UW Guide**, **U-65 Group UW Guide** and **Medicare UW Guide** are found in the Applicants section. Click on the link to view each guide.

Plan Selection

① Under the “**Location & Effective Date**” box - Notice that the County is populated based upon the Zip Code entered on The Main Agent Dashboard.

Plan Selection

Household Members

Payment

Summary

① Location & Effective Date

County

Zip Code

Harris

77084

Change

Choose Effective Date

② Billing Method

Individual Bill

Group Bill

EFT

CC

Note: Click the radio button to change/reselect the billing method.

Employee / Member ID

Affiliation Code

Plan Premiums

③ Applicants

U-65 UW Guide

U-65 Group UW Guide

MEDICARE UW Guide

Birth Date

Gender

Relationship

Tobacco User?

Est Points

04/04/1970

Male

Female

self

+ Add Another Person

④ Choose Plan

+ Health Saver Plus Gold (Indemnity Benefit Coverage)

+ Medicare Supplement

+ Enhanced 24 Hour Accident Expense Insurance Plan

+ Critical Illness Insurance

Plan Selection

Plan Selection

Household Members

Payment

Summary

1 Location & Effective Date

County

Zip Code

Harris

77084

Change

Choose Effective Date

2 Billing Method

Individual Bill

Group Bill

EFT

CC

Note: Click the radio button to change/reselect the billing method.

Employee / Member ID

Affiliation Code

Plan Premiums

3 Applicants

U-65 UW Guide

U-65 Group UW Guide

MEDICARE UW Guide

Birth Date

Gender

Relationship

Tobacco User?

Est Points

04/04/1970

Male

Female

self

Add Another

4 Choose Plan

Health Saver Plus Gold (Indemnity Benefit Coverage)

Medicare Supplement

Enhanced 24 Hour Accident Expense Insurance Plan

Critical Illness Insurance

note!

Estimated points are for quote purposes only, actual points ratings will be calculated and the premium adjusted accordingly once all Health Questions have been answered.

Please refer to the **U-65 UW Guide** for more information on estimated point values.

Plan Selection

Plan Selection

Household Members

Payment

Summary

① Location & Effective Date

③ Applicants

[U-65 UW Guide](#) [U-65 Group UW Guide](#) [MEDICARE UW Guide](#)

Birth Date	Gender	Relationship	Tobacco User?	Est Points
04/04/1970	☐ Male ☒ Female	self	☐	

+ Add Another Person

② Billing Method

☒ Individual Bill ☐ Group Bill
☒ EFT ☐ CC

Note: Click the radio button to change/reselect the billing method.

Employee / Member ID Affiliation Code

Plan Premiums

④ Choose Plan

- + Health Saver Plus Gold (Indemnity Benefit Coverage)
- + Medicare Supplement
- + Enhanced 24 Hour Accident Expense Insurance Plan
- + Critical Illness Insurance

③ **Applicant Information:**
Enter the *Birth Date*, *Gender*, *Tobacco User* check box and *Est. Points* (if applicable) for the applicant.

Plan Selection

Plan Selection

Household Members

Payment

Summary

1

Location & Effective Date

County

Zip Code

Harris

77084

Change

Choose Effective Date

2

Billing Method

Individual Bill

Group Bill

EFT

CC

Note: Click the radio button to change/reselect the billing method.

Employee / Member ID

Affiliation Code

Plan Premiums

3

Applicants

U-65 UW Guide

U-65 Group UW Guide

MEDICARE UW Guide

Birth Date

Gender

Relationship

Tobacco User?

Est Points

04/04/1970

Male

Female

self

+ Add Another Person

4

Choose Plan

+ Health Saver Plus Gold (Indemnity Benefit Coverage)

+ Medicare Supplement

+ Enhanced 24 Hour Accident Expense Insurance Plan

+ Critical Illness Insurance

③ **Add Another person:**
Click on the +
"Add Another Person" box to add another person to the application.

Plan Selection

Plan Selection

Household Members

Payment

Summary

1

Location & Effective Date

County

Zip Code

Harris

77084

Change

Choose Effective Date

2

Billing Method

Individual Bill

Group Bill

EFT

CC

Note: Click the radio button to change/reselect the billing method.

Employee / Member ID

Affiliation Code

Plan Premiums

Monthly Premium

\$0.00

Application Fee(s)

\$0.00

3

Applicants

U-65 UW Guide

U-65 Group UW Guide

MEDICARE UW Guide

Birth Date

Gender

Relationship

Tobacco User?

Est Points

04/04/1970

Male

self

Yes

05/05/1970

Male

Spouse

+ Add Another Person

4

Choose Plan

Health Saver Plus Gold (Indemnity Benefit Coverage)

Medicare Supplement

Enhanced 24 Hour Accident Expense Insurance Plan

Critical Illness Insurance

③ Add Another person:
Enter the *Birth Date*, *Gender*, *Relationship*, *Tobacco User* check box and *Est. Points* (if applicable) for the each new applicant added.

Plan Selection

Plan Selection

Household Members

Payment

Summary

① Location & Effective Date

County

Harris

Zip Code

77084

Change



Choose Effective Date

③ Applicants

[U-65 UW Guide](#)

[U-65 Group UW Guide](#)

[MEDICARE UW Guide](#)

Birth Date

04/04/1970

Gender

☐ Male

☒ Female

Relationship

self

Tobacco User?

☒ Yes

Est Points

Birth Date

05/05/1970

Gender

☒ Male

☐ Female

Relationship

Spouse

Tobacco User?

☐

Est Points



+ Add Another Person

④ Choose Plan

Select the product(s) you want to quote by clicking on the '+' sign to the left of the product name.

Billing Method

Bill

☐ Group Bill

☐ CC

button to change/reselect the billing method.

Affiliation Code

Plan Premiums

Monthly Premium

\$0.00

Application Fee(s)

\$0.00

④ Choose Plan



Health Saver Plus Gold (Indemnity Benefit Coverage)



Medicare Supplement



Enhanced 24 Hour Accident Expense Insurance Plan



Critical Illness Insurance

Plan Selection

Select the benefits to quote for the product from the Filters box.

note!

You can enter multiple variables for the product to compare prices in the **Filters** box.

Employee / Member ID

Affiliation Code

Plan Premiums

Monthly Premium	\$0.00
Application Fee(s)	\$0.00
Total Initial Premium (including fees)	\$0.00

Click to continue >>

Filters

Calendar Year Maximum Benefit

☒ \$250,000
 ☐ \$500,000
 ☐ \$1,000,000

Calendar Year Confinement Deductible

☐ \$100
 ☐ \$500
 ☐ \$1,000
 ☒ \$2,500
 ☒ \$5,000
 ☐ \$7,500
 ☐ \$10,000

Units

☐ 1
 ☒ 2
 ☐ 3

4

Choose Plan

Health Saver Plus Gold (Indemnity Benefit Coverage)

Health Saver Plus Gold (Indemnity Benefit Coverage)

Indemnity Benefit Policy

\$250,000 CY Max \$2,500 CY Ded 2 Units

Select Plan

Critical Illness Rider

Primary

None

Spouse/Domestic Partner

None

Child

None

Monthly Payment

\$434.01

[Brochure](#)
[Outline of Coverage](#)
[More Details](#)

Health Saver Plus Gold (Indemnity Benefit Coverage)

Health Saver Plus Gold (Indemnity Benefit Coverage)

Indemnity Benefit Policy

\$250,000 CY Max \$5,000 CY Ded 2 Units

Select Plan

Critical Illness Rider

Primary

None

Spouse/Domestic Partner

None

Child

None

Monthly Payment

\$347.21

[Brochure](#)
[Outline of Coverage](#)
[More Details](#)

Plan Selection

Employee / Member ID
Affiliation Code

Plan Premiums

Monthly Premium **\$0.00**
Application Fee(s) \$0.00
Total Initial Premium (including fees) \$0.00

Click to continue >>

Filters

Calendar Year Maximum Benefit
☒ \$250,000
☐ \$500,000
☐ \$1,000,000
Calendar Year Confinement Deductible
☐ \$100 ☐ \$500 ☐ \$1,000
☒ \$2,500 ☒ \$5,000 ☐ \$7,500
☐ \$10,000
Units
☐ 1 ☒ 2 ☐ 3

Choose Plan

Health Saver Plus Gold (Indemnity Benefit Coverage)

Indemnity Benefit Policy
\$250,000 CY Max \$2,500 CY Ded 2 Units

Select Plan

Critical Illness Rider
Primary
None
Spouse/Domestic Partner
None
Child
None
Monthly Payment
\$434.01

\$2,500 Calendar Year Confinement Deductible (Max 3 per policy per covered person)
\$5,000,000 Lifetime Maximum per policy
Choice of seven Calendar Year Confinement Deductibles and three benefit options
Use any Doctor or Hospital you choose without penalty
For additional savings the PHCS network is available at no additional cost
TelaDoc, Karis Group and Scriptsave benefits included at no additional cost

Brochure
Outline of Coverage
More Details

Health Saver Plus Gold (Indemnity Benefit Coverage)

Indemnity Benefit Policy
\$250,000 CY Max \$5,000 CY Ded 2 Units

Select Plan

Critical Illness Rider
Primary
None
Spouse/Domestic Partner
None
Child
None
Monthly Payment
\$347.21

\$5,000 Calendar Year Confinement Deductible (Max 3 per policy per covered person)
\$5,000,000 Lifetime Maximum per policy
Choice of seven Calendar Year Confinement Deductibles and three benefit options
Use any Doctor or Hospital you choose without penalty
For additional savings the PHCS network is available at no additional cost
TelaDoc, Karis Group and Scriptsave value added benefits included at no additional cost

Brochure
Outline of Coverage
More Details

The available Plan Riders are shown and can be selected from the drop down menus.

Plan Selection

note

The “Plan Premiums” box will update with the monthly premium and any applicable application fees.

D
Affiliation Code

Plan Premiums

Monthly Premium	\$434.01
Application Fee(s)	\$30.00
Total Initial Premium (including fees)	\$464.01

Click to continue >>

MY PLAN SELECTIONS

Health Saver Plus Gold (Indemnity Benefit Coverage) Selected
09/02/2020 [Change](#)

Filters

Calendar Year Maximum Benefit

☒ \$250,000

☐ \$500,000

☐ \$1,000,000

Calendar Year Confinement Deductible

☐ \$100 ☐ \$500 ☐ \$1,000

☒ \$2,500 ☒ \$5,000 ☐ \$7,500

☐ \$10,000

Units

☐ 1 ☒ 2 ☐ 3

Deselect All

Choose Plan

Health Saver Plus Gold (Indemnity Benefit Coverage)

Indemnity Benefit Policy
\$250,000 CY Max \$2,500 CY Ded 2 Units

Deselect Plan

Critical Illness Rider

Primary
None

Spouse/Domestic Partner
None

Child
None

Monthly Payment

\$434.01

[Brochure](#)
[Outline of Coverage](#)
[More Details](#)

- \$2,500 Calendar Year Confinement Deductible (Max 3 per policy per covered person)
- \$5,000,000 Lifetime Maximum per policy
- Choice of seven Calendar Year Confinement Deductibles and three benefit options
- Use any Doctor or Hospital you choose without penalty
- For additional savings the PHCS network is available at no additional cost
- TelaDoc, Karis Group and Scriptsave value added benefits included at no additional cost

Health Saver Plus Gold (Indemnity Benefit Coverage)

Indemnity Benefit Policy
\$250,000 CY Max \$5,000 CY Ded 2 Units

Select Plan

Critical Illness Rider

Primary
None

Spouse/Domestic Partner
None

Child
None

Monthly Payment

\$347.21

[Brochure](#)
[Outline of Coverage](#)
[More Details](#)

- \$5,000 Calendar Year Confinement Deductible (Max 3 per policy per covered person)
- \$5,000,000 Lifetime Maximum per policy
- Choice of seven Calendar Year Confinement Deductibles and three benefit options
- Use any Doctor or Hospital you choose without penalty
- For additional savings the PHCS network is available at no additional cost
- TelaDoc, Karis Group and Scriptsave value added benefits included at no additional cost

Press the “**Select Plan**” button next to the plan you would like to enroll for your applicant. After the plan has been selected the “**Select Plan**” button will display as “**Deselect Plan.**”

Plan Selection

Plan Selection
Household Members
Payment
Summary

1
Location & Effective Date

County
Zip Code

2
Billing Method

☒ Individual Bill
☐ Group Bill

☒ EFT
☐ CC

Note: Click the radio button to change/reselect the billing method.

Employee / Member ID
Affiliation Code

Plan Premiums

Monthly Premium	\$434.01
Application Fee(s)	\$30.00
Total Initial Premium (including fees)	\$464.01

Click to continue >>

MY PLAN SELECTIONS

Health Saver Plus Gold (Indemnity Benefit Coverage) Selected
09/02/2020 [Change](#)

Filters

3
Applicants

U-65 UW Guide
U-65 Group UW Guide
MEDICARE UW Guide

Birth Date	Gender	Relationship	Tobacco User?	Est Points
04/04/1970	☐ Male ☒ Female	self	☒ Yes	
05/05/1970	☐ Male ☐ Female	Spouse	☐	

4
Choose Plan

Health Saver Plus Gold (Indemnity Benefit Coverage)

Medicare Supplement

Enhanced 24 Hour Accident Expense Insurance Plan

Critical Illness Insurance

Dental Choice Plus

GAP Insurance (Expense Incurred)

Cancer Policy

Catastrophic Accident Expense Policy

Specified Disease Policy

Medicare Advantage GAP (Indemnity)

Once all plan selections have been made, press the **“Click to continue >>”** button to proceed to the **“Household Members Tab”**.

Household Members

Plan Selection

Household Members

Payment

Summary

Household Members

Is HSP Gold Guaranteed Issue? *

No

First Name *

Lisa

MI

J

Last Name *

Era

Suffix

Select

Street Address *

11720 Katy Freeway

Apt or Unit

Gender

☐ Male
 ☒ Female

City *

Houston

State *

TX

Zip Code *

77084

Email *

bothannewera@gmail.com

Phone *

Mobile

☐ No Email Address

Electronic Consent *

Select

Applicant consents to receiving electronic communication from Philadelphia American Life Insurance Company through the use of the email address provided and has been notified that this consent can be withdrawn or the email address updated at any time by contacting the Company. Electronic communication means informational emails, notices and documents regarding the application and insurance coverage. Failure to receive such communication due to an incorrect email address is no fault of the Company. If the Company has reason to believe that Company communications have not been received, the Company will deliver all future communication by first-class mail.

Plan Premiums

Monthly Premium

\$434.01

Application Fee(s)

\$30.00

Total Initial Premium (including fees)

\$464.01

MY PLAN SELECTIONS

Health Saver Plus Gold (Indemnity Benefit Coverage) Selected

09/02/2020 [Change](#)

note!

Guaranteed Issue questions only apply for List bill or Pre-Approved Home Office Guaranteed Issue situations.

note!

Plan Premiums and My Plan Selections have carried over from the Plan Selection tab...

Household Members

Plan Selection
Household Members
Payment
Summary

Household Members

Is HSP Gold Guaranteed Issue? *

No

First Name *
Lisa

MI
J

Last Name *
Era

Suffix
Select

Street Address *
11720 Katy Freeway

Apt or Unit

Gender
☐ Male ☒ Female

City *
Houston

State *
TX

Zip Code *
77084

Email *
bothannewera@gmail.com

Phone *

Mobile

☐ No Email Address

Electronic Consent *

Select

Applicant consents to receiving electronic communication from Philadelphia American Life Insurance Company through the use of the email address provided and has been notified that this consent can be withdrawn or the email address updated at any time by contacting the Company. Electronic communication means informational emails, notices and documents regarding the application and insurance coverage. Failure to receive such communication due to an incorrect email address is no fault of the Company. If the Company has reason to believe that Company communications have not been received, the Company will deliver all future communication by first-class mail.

Plan Premiums

Monthly Premium	\$434.01
Application Fee(s)	\$30.00
Total Initial Premium (including fees)	\$464.01

MY PLAN SELECTIONS

Health Saver Plus Gold (Indemnity Benefit Coverage) Selected
09/02/2020 [Change](#)

Enter all Applicant Demographic Information. Fields marked with a "*" are required for Enrollment Progression.

Household Members

Email

Email *
bothanewera@gmail.com
☐ No Email Address

Phone *
(713) 555-0000

Mobile

Electronic Consent *
Select ▼

Applicant consents to receiving electronic communication from Philadelphia American Life Insurance Company through the use of the email address provided and has been notified that this consent can be withdrawn or the email address updated at any time by contacting the Company. Electronic communication means informational emails, notices and documents regarding the application and insurance coverage. Failure to receive such communication due to an incorrect email address is no fault of the Company. If the Company has reason to believe that Company communications have not been received, the Company will deliver all future communication by first-class mail.

Enter **Email** and the **Electronic Consent** section will be displayed.

Electronic Consent

Email *
dsj697775@gmail.com
☐ No Email Address

Phone *
(713) 298-9

Mobile

Electronic Consent *
Yes ▼

SSN *
789-56-2631

Birth State
DE ▼

Language
English ▼

Height *
6'0" ▼

Weight(pounds) *
200

Select "Yes" or "No" for the Electronic Consent.

No Email

Email

Phone *
(713) 298-9365

Mobile
(715) 886-6999

☒ No Email Address

If the "No email address" option button is checked then then Electronic Consent question will not be displayed.

Household Members

Plan Selection
Household Members
Payment
Summary

Household Members

Is HSP Gold Guaranteed Issue? *

No

First Name * MI Last Name * Suffix

Lisa J Era Select

Street Address * Apt or Unit Gender

11720 Katy Freeway O Male ☒ Female

City * State * Zip Code *

Houston TX 77084

Phone * Mobile

era@gmail.com

Consent *

Yes

SSN * Birth State Language

TX English

Height * Weight(pounds) *

Select

Plan Premiums

Monthly Premium	\$434.01
Application Fee(s)	\$30.00
Total Initial Premium (including fees)	\$464.01

MY PLAN SELECTIONS

Health Saver Plus Gold (Indemnity Benefit Coverage) Selected
09/02/2020 [Change](#)

Continue entering demographic information.

Household Members

SSN *	Birth State	Language				
123-45-6789	TX	English				
Height *	Weight(pounds) *					
5'9"	140					
Employment Information ☐ Not Employed/Not Applicable						
Employer	Job Title					
A PLUS CARE SOLUTION						
Street Address	Apt or Unit	City				
1408 N HIGHLAND STE 306		JACKSON				
Zip Code	State	Phone				
38301	TN	(731) 609-1749				
Work Hours *	Hire Date *	Annual Salary				
Occupation *						
Select						
Spouse or Domestic Partner Information						
First Name *	MI	Last Name *	Suffix	Gender	DOB *	Relationship *
SPOUSE		ERA	Select	☐ Male ☒ Female	05/05/1970	Spouse
Height *	Weight *	SSN				
5'6"	135					
					Birth State	
					FC	

Use the “**Save**” button below to save your progress as you enter the application.

Save

If the applicant’s Birth State is a foreign country then select **FC**.

Household Members

note!

Employment Information:

This section is automatically populated with the employer information when the client selects "list bill". The work hours and hire date become mandatory fields to complete.

Employment Information ☐ Not Employed/Not Applicable

Employer

A PLUS CARE SOLUTION!

Job Title

Street Address

1408 N HIGHLAND STE 306

Apt or Unit

City

JACKSON

Zip Code

38301

State

TN ▼

Phone

(731) 609-1749

Work Hours *

40

Hire Date *

06/18/2006

Annual Salary

Occupation *

Other ▼

Occupation description *

Analyst

If the applicant is not employed (other than retired), please select "Other" in the Occupation drop down and indicate reason for Unemployment in the 'Occupation Description' field.

note!

If any occupation from the drop down box is selected the applicant will not be eligible for coverage.

Household Members

Policy Questions

Beneficiaries only have to be entered once if it's the same person for all products. Click the **"apply to all"** option button. Different beneficiaries can apply to each product.

Policy Questions - Indemnity Benefit Policy

Primary Beneficiary *

☒ apply to all

Charles Era



Secondary Beneficiary

Charles Era



Household Members

Policy Questions

Within the past 10 years, has any applicant been diagnosed with or received treatment by a physician, tested positive or taken medication for any of the following conditions? Liver cirrhosis, Hepatitis B, insulin-diabetes and/or neuropathy, ulcerative colitis or Crohn's, Down's syndrome, intellectual disability, Autism, Rheumatoid Arthritis, ALS (Lou Gehrig's Disease), Alzheimer's, Parkinson's, Dementia, cystic fibrosis, heart attack, coronary bypass, coronary artery disease, cerebral palsy, sickle cell or aplastic anemia, leukemia, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, suicide attempt, Stroke or TIA, paraplegia or quadriplegia, kidney or renal failure, or been hospitalized more than 3 times in the past year? *

Lisa Era

Charles Era

No

No

☒ No To All

In the past 10 years, has any applicant tested positive or been diagnosed with or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? *

Lisa Era

Charles Era

No

No

☒ No To All

Is the primary applicant or any of the applicant's dependent's (spouse, child(ren) under age 25), whether applying for coverage currently pregnant or have a pending adoption? *

Lisa Era

Charles Era

No

No

☒ No To All

Within the past 5 years has any applicant been diagnosed with, taken medication or been treated by a physician for internal malignant melanoma or any other malignancy or been advised to have any diagnostic tests relating to cancer which have not been completed or for which results have not been received? *

Lisa Era

Charles Era

No

No

☒ No To All

Within the past 4 years has any applicant used drugs, been diagnosed with or received any medical treatment, taken medication for or been advised to have a medical test for alcohol or drug abuse? *

Lisa Era

Charles Era

No

No

☒ No To All

Answers to Health Questions can be answered Individually for each plan participant or "No to All" can be selected and applied to all.

Household Members

Primary Doctor Entry

Primary Doctor of each Applicant who has current and complete medical records (use Agent Notes section if more space is needed)

Doctor's Name	Street Address	Apt or Unit	City
Dr Oz	1 Medical Center		Houston
Zip Code	State	Phone	
77063	TX	(713) 555-0000	

House or Domestic Partner's (Dependent 1) Doctor Address

Doctor's Name	Street Address	Apt or Unit	City
Dr Oz	1 Medical Center		Houston
Zip Code	State	Phone	
77063	TX	(713) 555-0000	

Enter Doctor's name and information here for all applicants.

- Primary
- Spouse

Household Members

Primary Doctor Entry

Enter “**Best time to call**” and “**Best Phone**”.

Best time to call *

5 PM

Best Phone *

(713) 555-0000

Continue >>

Click the **continue>>** button to view the Payment page.

Payment

EFT Payment Information

Select the **"Payor Relationship"**.
The **"Name as it appears on the bank account"** and **"Billing Address"** can be changed in this section if the Payor Relationship is different to the Insurer.

Plan Selection

Household Members

Payment

Summary

Payor Relationship

Primary Applicant

Billing Address

Defaults to primary applicant information - all fields are editable

Name as it appears on bank account

Lisa Era

Billing Address Line1

11720 Katy Freeway

Billing Address Line2

City

Houston

Zip Code

77084

State

TX

County

Harris

Payment Information

Bank Account

Account Type

Checking

ABA Routing Number

051000020

Bank Name

SUNTRUST

Account Number

265646461

Authorization To My Bank

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of New Era Life Insurance Company, New Era Life Insurance Company of the Midwest, and Philadelphia American Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original.

Applicant Statement, Disclosure and Disclaimer Notice Documents

Open the documents below linked to each product's application and review with client before proceeding.

Health Saver Plus Gold (Indemnity Benefit Coverage)

Continue

Payment Information: Enter Checking or Savings Account Information for Payment Authorization and Drafting.

If the Account is a Company Account select the Business Checking account type.

Click continue to view the Summary page.

Payment

EFT Payment Authorization

Plan Selection

Household Members

Payment

Summary

Payor Relationship

Primary Applicant

Billing Address

Defaults to primary applicant information - all fields are editable

Name as it appears on bank account

Lisa Era

Billing Address Line1

11720 Katy Freeway

Billing Address Line2

City

Houston

Zip Code

77084

State

TX

County

Harris

Payment Information

Bank Account

Account Type

Checking

ABA Routing Number

051000020

Bank Name

SUNTRUST

Account Number

265646461

Authorization To My Bank

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of New Era Life Insurance Company, New Era Life Insurance Company of the Midwest, and Philadelphia American Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original.

Applicant Statement, Disclosure and Disclaimer Notice Documents

Open the documents below linked to each product's application and review with client before proceeding.

Health Saver Plus Gold (Indemnity Benefit Coverage)

Applicant Statement, Disclosures and Disclaimer Notice Documents must be reviewed with your client.

Each document pending review will be shaded in **green**. Documents that have been opened and review completed will be shaded in **blue**.

Click continue to view the Summary page.

Continue

Payment

Applicant Statement, Disclosure and Disclaimer Notice Documents

When the document is selected, it will generate a viewing window as shown here.

The documents can be downloaded and printed to provide to your clients if you would like to do so as well.

Once the document has been reviewed with your client, click the **“Review Completed”** Button to return to the document list.

Health Saver Plus Gold (Indemnity Benefit Coverage)

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY
P. O. Box 4884, Houston, Texas 77210

HSPG - TX

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

Review Completed

Account Number: 265646461

Zip Code: 77084 State: TX County: Harris

Attention To My Bank

I hereby request and authorize you to pay and charge my account, checks drawn on my account by the order of New Era Life Insurance Company, New Era Life Insurance Company of the Midwest, and Philadelphia American Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks are dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original.

Applicant Statement, Disclosure and Disclaimer Notice Documents

Open the documents below linked to each products application and review with client before proceeding.

Health Saver Plus Gold (Indemnity Benefit Coverage)

Continue

Payment

List Bill Authorization

No Payment Information
is required for List Bill.

Plan Selection

Household Members

Payment

Summary

Payment Information

Premiums will be paid by authorized payroll deductions through employer.

Authorization for Payroll Deduction
I hereby request and authorize my employer to deduct from my salary for benefits offered by Philadelphia American Life Insurance Company.
This authorization shall remain in effect until termination of my employment or written notice by me of the cancellation of this authorization.

Applicant Statement, Disclosure and Disclaimer Notice Documents
Open the documents below linked to each product's application and review with client before proceeding.

Health Saver Plus III (Indemnity Health Coverage)

Dental Choice Plus

Critical Illness Insurance

Continue

Payment

Credit Card Authorization

Plan Selection

Household Members

Payor Relationship

Insured

Enter Payment Information

Click to Enter Payment Information

CREDIT CARD AUTHORIZATION

I hereby request and authorize regularly scheduled charges to my credit card to New Era Life Insurance Company, New Era Life Insurance Company of the Midwest (Company) and I understand that I will be charged each policy billing period for these charges in accordance with the issuing bank's cardholder agreement. I further understand that whether intentionally or inadvertently, the company shall not be responsible for any such dishonor results in the forfeiture of insurance and that I am responsible for such dishonor or reversed payment.

I further understand that this authorization will remain in effect until I cancel it or any changes to my account information or termination of this authorization at any time.

I hereby certify that I am an authorized user on this account and I will not dispute any charges that correspond to the terms indicated. My typed name should be honored as if it were my own.

Applicant Statement, Disclosure and Disclaimer Notice Documents

Open the documents below linked to each product's application and review with your agent.

Health Saver Plus Gold (Indemnity Benefit Coverage)

Dental Choice Plus

Save a Fund

Save payment method for later

Enter billing account email address:

bothanera@gmail.com

Lisa Era

4111 1111 1111 1111

VISA

06 / 23

123

Enter Billing Information

Save a Fund

Save payment method for later

Card Information:

Lisa Era

Visa (1111)

06 / 2023

11720 Katy Freeway

Houston

77084

United States X

Texas X

Save Card For Future Payments

Continue

To add the credit card information, click on **Click To enter Payment Information** the **Save a Fund** box will be displayed. Enter the Credit Card information then click **Enter Billing Information**. An updated box will show the saved credit card information. Click on **Save Card For Future Payments**. To make changes to the credit card added, then new Credit Card information will need be added.

Click **Continue** to go to the Summary page.

Payment

Credit Card Authorization

Plan Selection

Household Members

Payment

Summary

Payor Relationship

Insured

Enter Payment Information

☒ VISA ending with 1111

Click Here to Add Another Card

Confirmation that the credit card payment information has been saved is displayed.

If a change needs to be made to the credit card number, click on the **Click Here to Add Another Card** button.

CREDIT CARD AUTHORIZATION

I hereby request and authorize regularly scheduled charges to my credit card to New Era Life Insurance Companies (including New Era Life Insurance Company, New Era Life Insurance Company of the Midwest, and Philadelphia American Life Insurance Company) and I understand that I will be charged each policy billing period for the premium due. I agree that I will pay for these charges in accordance with the issuing bank's cardholder agreement. I further agree that if a charge is dishonored with or without cause and whether intentionally or inadvertently, the company shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance and that I am responsible for any fees incurred by the company as a result of such dishonored or reversed payment.

I further understand that this authorization will remain in effect until I cancel it in writing and agree to notify the company of any changes to my account information or termination of this authorization at least 15 days prior to the next billing period.

I hereby certify that I am an authorized user on this account and I will not dispute any payment so long as the transaction corresponds to the terms indicated. My typed name should be honored as if it were my original signature.

Enrollment

Payment Information - EFT

Plan Selection Household Members **Payment** Summary

Payor Relationship

Payor Relationship
Insured ▼

Billing Address
Defaults to primary applicant information - all fields are editable

Name as it appears on bank account
Winifred K Marrs

Billing Address Line1
54 Park Street

Billing Address Line2

City Zip Code State County
Houston 77047 TX Harris ▼

Payment Information

Bank Account +

Account Type
Checking ▼

ABA Routing Number

Bank Name

Account Number

The Payor Relationship automatically defaults to the Insured. If it is different, click the drop down box and select the correct option.

The Account Holder's Name and Billing Address automatically populates to the payment tab. If the address is different than the Primary client's, change it in this section.

On the Payment Information section, enter Bank Account information. If Account is a Company Account select Business Checking from the drop down box.

Payment

Applicant Statement, Disclosure and Disclaimer Notice Documents

Plan Selection

Household Members

Payment

Summary

Payor Relationship

Primary Applicant

Billing Address

Defaults to primary applicant information - all fields are editable

Name as it appears on bank account

Lisa Era

Billing Address Line1

11720 Katy Freeway

Billing Address Line2

City

Zip Code

State

County

Houston

77084

TX

Harris

Payment Information

Bank Account

Account Type

Checking

ABA Routing Number

051000020

Bank Name

SUNTRUST

Account Number

265646461

Authorization To My Bank

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of New Era Life Insurance Company, New Era Life Insurance Company of the Midwest, and Philadelphia American Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original.

Applicant Statement, Disclosure and Disclaimer Notice Documents

Open the documents below linked to each product's application and review with client before proceeding.

Health Saver Plus Gold (Indemnity Benefit Coverage)

Continue

Once all Payment Information has been entered and all Documents have been reviewed and are displaying blue, then, press the **“Continue”** button to proceed to the summary page.

Summary

Plan Selection

Household Members

Payment

Summary

Summary of Coverage

Insurance Coverage Purchased

Date Prepared: 08/26/2020

Requested Effective Date: 09/02/2020

Plan Name : Indemnity Benefit Policy

Details :

Calendar Year Maximum:

\$250,000

Calendar Year Confinement Deductible:

\$2,500

Number of Benefit Units:

2 Units

Covered:

DOB:

Relationship:

Lisa Era

04/04/1970

Self

Charles Era

05/05/1970

Spouse

Monthly Premium:

\$434.01

Non Refundable Application Fee:

\$30.00*

Total Initial Premium:

\$464.01

Total Monthly Thereafter:

\$434.01

Commission

Agent or Producer Name

Split Agent or Producer Number

Split Percentage

SONJA HOME OFFICE

600998843

100%

Total Initial Premium:

\$464.01

Total Monthly Premium:

\$434.01

*Application fees may be refundable in certain states. Please consult your sales material or contact the Home Office if you require additional information.

The Summary of Coverage page will show the coverage for all participants and the products selected for enrollment.

Summary

The system will automatically default to the Agent Number approved to write the applicable product in that state.

If there is more than one Agent Number select the correct Agent Number from the drop-down list.

Plan Selection
Household Members
Payment
Summary

Summary of Coverage

Insurance Coverage Purchased

Date Prepared: 08/26/2020
Requested Effective Date: 09/02/2020

Plan Name : Indemnity Benefit Policy
[Brochure](#)

Details :
Calendar Year Maximum: \$250,000
Calendar Year Confinement Deductible: \$2,500
Number of Benefit Units: 2 Units

Covered:	DOB:	Relationship:
sonja Era	04/04/1970	Self
sonja Era	05/05/1970	Spouse

Application Fee:	\$434.01
Total Initial Premium:	\$30.00*
Total Monthly Premium:	\$464.01
Total Monthly Premium:	\$434.01

Commission

Agent or Producer Name	Split Agent or Producer Number	Split Percentage
SONJA HOMEOFFICE	600998843	100%

Total Initial Premium:

\$464.01

Total Monthly Premium:

\$434.01

*Application fees may be refundable in certain states. Please consult your sales material or contact the Home Office if you require additional information.

Summary

new split agent or producer Number

Writing Number: Commission (%): ADD

Agent or Producer Use Only

* Did you personally meet with each Applicant?

* I have truly and accurately recorded the information as herein supplied by the Applicant #1 for all family members.

* Will this coverage applied for replace or effect a change of any coverage with this or any other company?

* I have left or made available an Outline of Coverage and/or a Disclosure Notice as required by law.

Mail Policy To *

If you choose this delivery option, you will be required to obtain a signed Delivery Receipt from your client which must be returned to the home office within 10 days.

☒ I confirm that I have read and reviewed the Outline of Coverage and Disclosure Statement providing basic information about the cost and coverage of the insurance being applied for to the applicant. I have also notified the applicant that an electronic copy of the Outline of Coverage will be delivered to the email address provided during the application process upon submission of the application.

For Medicare Supplement applications: I additionally certify that I have given the "Guide to Health Insurance for People with Medicare" and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage.

Agent or Producer Signature *

City *

State *

SUBMIT

"Add Split Agent or Producer Number" is used to split commissions with another Agent/Producer. Enter the split agents Writing Number and the Commission percent for click the **ADD** button.

Summary

Commission Split-Add New Agent or Producer

Plan Selection

Household Members

Payment

Summary

note!

The system will add the new agent number and percentage to each product summary. The program will automatically deduct the new agents percentage from the primary agents percentage. If there was an entry error, the agent number can be deleted by clicking the trash can or can be modified by clicking the pencil icon.

Summary of Coverage

Insurance Coverage Purchased

Date Prepared: 06/02/2020

Requested Effective Date: 06/09/2020

Plan Name : Indemnity Benefit Policy

[Brochure](#)

Details :

Calendar Year Maximum: \$250,000
Calendar Year Confinement Deductible: \$2,500
Number of Benefit Units: 2 Units

Covered:	DOB:	Relationship:
Lisa Era	04/04/1970	Self
Michael Era	05/05/1970	Spouse
Monthly Premium:		\$450.70
Non Refundable Application Fee:		\$30.00*
Total Initial Premium:		\$480.70
Total Monthly Thereafter:		\$450.70

Commission

Agent or Producer Name	Split Agent or Producer Number	Split Percentage	Action
SONJA HOMEOFFICE	600998843	75%	
CRISSA HOMEOFFICE	600998844	25%	 

Total Initial Premium:	\$480.70
Total Monthly Premium:	\$450.70

Summary

Agent or Producer Use Only

“Agent or Producer Use Only” questions are listed under this section. These Questions are marked with an * as they are required.

Add Split Agent or Producer Number

Writing Number: Commission (%): **ADD**

Agent or Producer Use Only

Yes * Did you personally meet with each Applicant?

Yes * I have truly and accurately recorded the information as herein supplied by the Applicant #1 for all family members.

No * Will this coverage applied for replace or effect a change of any coverage with this or any other company?

Yes * I have left or made available an Outline of Coverage and/or a Disclosure Notice as required by law.

Mail Policy To *
Agent or Producer

If you choose this delivery option, you will be required to obtain a signed Delivery Receipt from your client which must be returned to the home office within 10 days.

☒ I confirm that I have read and reviewed the Outline of Coverage and Disclosure Statement providing basic information about the cost and coverage of the insurance being applied for to the applicant. I have also notified the applicant that an electronic copy of the Outline of Coverage will be delivered to the email address provided during the application process upon submission of the application.

For Medicare Supplement applications: I additionally certify that I have given the "Guide to Health Insurance for People with Medicare" and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage.

Agent or Producer Signature *

City *

State *
 TX

SUBMIT

note!

Agent or Producer Signature:

The system will default to the to agents residence City and State. If the agent is taking an application in another state the City and State will need to be updated.

Summary

Submit Application

Add Split Agent or Producer Number

Writing Number: Commission (%): [ADD](#)

Agent or Producer Use Only

* Did you personally meet with each Applicant?

* I have truly and accurately recorded the Information as herein supplied by the Applicant #1 for all family members.

* Will this coverage applied for replace or effect a change of any coverage with this or any other company?

* I have left or made available an Outline of Coverage and/or a Disclosure Notice as required by law.

Mail Policy To *

If you choose this delivery option, you will be required to obtain a signed Delivery Receipt from your client which must be returned to the home office within 10 days.

☒ I confirm that I have read and reviewed the Outline of Coverage and Disclosure Statement providing basic information about the cost and coverage of the Insurance being applied for to the applicant. I have also notified the applicant that an electronic copy of the Outline of Coverage will be delivered to the email address provided during the application process upon submission of the application.

For Medicare Supplement applications: I additionally certify that I have given the "Guide to Health Insurance for People with Medicare" and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage.

Agent or Producer Signature *

City *

State *

[SUBMIT](#)

When all Agent or Producer Use Only questions have been answered and Agent Signature has been completed, press the **Submit** button to submit the Application.

Confirmation Screen

Application Submitted

Once the application has been submitted the **Confirmation Screen**, will be displayed.

Thank You

Thank you, your application has been submitted.

Insurance Coverage Purchased

Date Prepared: 06/02/2020
Requested Effective Date: 06/09/2020
Status: Completed

Plan Name : Indemnity Benefit Policy

[Brochure](#)

Details :

Calendar Year Maximum:	\$250,000
Calendar Year Confinement Deductible:	\$2,500
Number of Benefit Units:	2 Units

Covered:

Lisa Era

DOB:

04/04/1970

Relationship:

Self

Michael Era

05/05/1970

Spouse

Monthly Premium:

Non Refundable Application Fee:

Total Initial Premium:

Total Monthly Thereafter:

\$450.70

\$30.00*

\$480.70

\$450.70

Total Initial Premium:

\$480.70

Total Monthly Premium:

\$450.70

*Application fees may be refundable in certain states. Please consult your sales material or contact the Home Office if you require additional information.

Email

Print

The Confirmation Summary can be printed by selecting the **Print** button here.

If you would like to Email the Confirmation to the client, press the **Email** button.

note!

If the applicants email was not entered on the Household Information Page then no Email button will display here.

Main Agent Dashboard

Enter Zipcode

New App >>

Welcome: DORAUN HOME OFFICE

279



Completed Apps

48

Incomplete Apps

Lead

After the application has been submitted it will show up in Completed Apps on the Main Agent Dashboard.

The information contained on this Web Site does not constitute investment advice, and is not an offer to sell or a solicitation to buy any security or any insurance product. All insurance and/or securities transactions require signed agreements between New Era Life Insurance Companies and its customers, and the terms of those agreements are binding on the parties. No other representation, whether made in person, on-line, electronically, in written, graphical, or verbal communication, may alter the terms of those agreements except that your use of this Web Site constitutes your agreement to the additional Terms of Use applicable to such use. Some products may not be available in all jurisdictions. In addition, any prospectus information available on this Site is posted for informational purposes only.

[Terms and Conditions](#) | [Privacy Policy](#)

Thank you!!

You have now reviewed the New Era Life Insurance
U-65
Enrollment User Guide.