PENN TREATY NETWORK AMERICA INSURANCE COMPANY[SM]

ALLENTOWN, PENNSYLVANIA

ACKNOWLEDGMENT OF NONDUPLICATION FOR APPLICANTS AGE 65 AND OLDER

PLEASE READ CAREFULLY BEFORE SIGNING

I, _____ certify that I have done the following:
(Agent's Name)

1. Informed the undersigned applicant of the right to have all existing health insurance policies presently in force reviewed by me to determine whether any duplicate coverage will occur with the issuance of this policy.

2. Reviewed the policies listed below and have found that duplication WILL/WILL NOT occur with the issuance of the following policy:

COMPANY	POLICY NUMBER	TYPE OF COVERAGE

_____ Duplication will not occur because the above-listed polic(y)(ies) will be replaced by the applied for policy.

_____ No health policies in force at this time.

_____ Applicant has elected not to have the Polic(y)(ies) reviewed.

_____

DATE AGENT

I certify that I have been informed of my right to have all my existing health policies reveiwed and:

_____ I have been informed that the policy for which I am applying WILL/WILL NOT result in duplicate coverage.

_____ I have elected not to have my policies reviewed.

_____

DATE APPLICANT

ORIGINAL TO COMPANY - COPY TO APPLICANT

ACK(IA)
Kenneth Wheeler 60484