

MEDICARE SUPPLEMENT COVERAGE APPLICATION

SECTION I – Proposed Insured information

APPLICANT NAME (exactly as it appears on your Medicare Health Insurance card)

First name	Middle initial	Last name
Date of birth (MM/DD/YYYY)	Age (at Effective Date)	Social Security Number
Gender (select one)	Phone number(s) (with area code)	
<input type="checkbox"/> Male <input type="checkbox"/> Female	<i>Mobile:</i>	<i>Home:</i>

Resident address

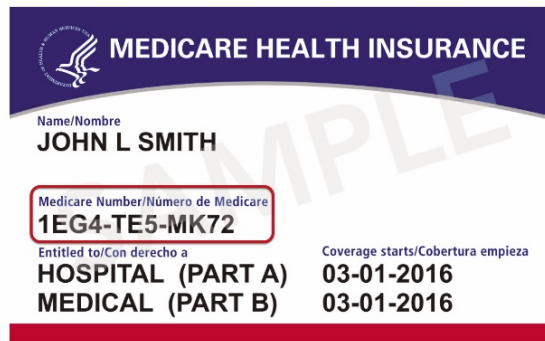
City	State	ZIP code
-------------	--------------	-----------------

Mailing address (if different from Resident address)

City	State	ZIP code
-------------	--------------	-----------------

Medicare Number (exactly as it appears on your Medicare Health Insurance card; see below sample)

Medicare Health Insurance card sample:



ALL PAGES OF THE APPLICATION MUST BE SUBMITTED

SECTION II – Plan and payment information

Plan	Requested policy effective date	
Household premium discount		
<input type="checkbox"/> Yes (please complete the Household Discount form) <input style="margin-left: 150px;" type="checkbox"/> No		
Modal Premium	Policy fee	Premium collected
\$	\$	\$
Payment method (select one):		Payment mode (select one):
<input type="checkbox"/> Billed (select one): <input type="checkbox"/> Bank draft (select one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings		<input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (bank draft only) <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual Routing Number: _____ Account Number: _____

SECTION III – Eligibility questions (please answer all questions)

1. Within the past twelve (12) months, have you used any tobacco or nicotine products, including: - cigarettes - cigars - pipes - vapes - chewing tobacco - nicotine gum/patches - eCigarettes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Are you covered under Medicare Part A? If NO, what is your future Part A eligibility date? (MM/DD/YYYY) If YES, what is your Part A effective date? (See "Coverage starts" on your Medicare Health Insurance card. MM/DD/YYYY)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you covered under Medicare Part B? If NO, what is your future Part B eligibility date? (MM/DD/YYYY) If YES, what is your Part B effective date? (See "Coverage starts" on your Medicare Health Insurance card. MM/DD/YYYY)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you enrolled in Medicare Part B more than once?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Are you applying during a guaranteed issue period? (If YES, you must attach your proof of eligibility to this application.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you are applying during an *Open Enrollment* or a *Guaranteed Issue* period, **go to SECTION VII – Replacement questions.**

If not, please proceed to **SECTION IV – Health questions.**

SECTION IV – Health questions

Please answer ALL of the following questions.

If you answer YES to any questions from 2 to 9 in this section, you are not eligible for coverage.

1. Height (<i>feet and inches</i>):	Weight (<i>pounds</i>):		
2. - Are you bedridden or confined to a wheelchair, - do you require the assistance of a motorized mobility device, or - have you had any amputation caused by disease?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you: - currently hospitalized, - in a nursing home or assisted living facility, - or have you been hospitalized three or more times in the past two years?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Are you currently receiving any: - occupational, speech, or physical therapy, or - services from a home healthcare agency?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you been advised by a physician to have any of the following that have not been performed: - surgery (including cataract or joint replacement surgery), - medical tests, infusions, or therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you been medically diagnosed and treated by a member of the medical profession for any of the following:			
a) Cognitive or nervous system disorders:			
i) Parkinson's disease	ii) Dementia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
iii) Multiple or amyotrophic lateral sclerosis	iv) Muscular Dystrophy		
v) Alzheimer's disease	vi) Any other cognitive disorder?		
b) - Acquired immune deficiency syndrome (AIDS), - AIDS related complex (ARC), or - human immunodeficiency virus (HIV) infection?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) - Chronic kidney disease stage 3-5, - kidney insufficiency, or - renal failure requiring dialysis?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) - Emphysema, - chronic obstructive pulmonary disease (COPD), - any other chronic pulmonary condition, or - any medical condition requiring the use of oxygen?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) - Systemic lupus, - scleroderma, or - myasthenia gravis?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

SECTION IV – Health questions (continued)

g) Chronic hepatitis or cirrhosis of the liver?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h) Cardiac defibrillator implantation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you been medically diagnosed and treated by a member of the medical profession for any of the following in the last two (2) years:		
a) - Heart attack, - cardiac angioplasty, or	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Vascular angioplasty - endarterectomy, or	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) A stroke or transient ischemic attack (TIA)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you had, been treated for, or been advised by a physician within the last two (2) years to have treatment for:		
a) Alcoholism or drug abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) - Internal cancer (examples include but are not limited to breast, lung or liver cancer, etc.), - leukemia, - Hodgkin's disease, or	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Arthritis that restricts mobility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Do you have diabetes or take medication to control your blood sugar? If YES, please answer each of the following questions (a to d). If NO, please answer each question (a to d) with 'NO'.		
a) Have you ever required or been advised to take more than fifty (50) units of insulin daily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Do you take three (3) or more medications (oral or injections) to control your blood sugar?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Do you take four (4) or more medications to control your high blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Have you been diagnosed with or treated for any of the following conditions: - peripheral vascular disease, - peripheral venous thrombotic disease, - peripheral artery disease, - kidney disease, - kidney failure,	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SECTION V – Consideration health questions

If you answer **YES** to any of the following health questions, your application will be submitted to underwriting for further review.

10. Are you currently receiving, or have you been advised to receive injections in a physician's office?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
11. Have you had or been treated for or been advised by a physician to have treatment within the last two (2) years for:			
a) - Coronary artery disease, - angina, - aortic or cardiac aneurysm, - cardiomyopathy, or	- congestive heart failure, - heart valve disorder, - atrial fibrillation, - other heart rhythm disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) - Peripheral artery disease, - peripheral vascular disease, or	- peripheral venous thrombotic disease, - carotid artery disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) - Degenerative bone disease, - spinal stenosis?	- rheumatoid arthritis, or	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Any mental or nervous disorder requiring treatment by a psychiatrist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

If you answered **YES** to any of the questions in this section (V), please provide dates and details regarding your treatment below.

SECTION VI – Medication history

Are you taking or have you taken any prescription or over-the-counter medications within the past twelve (12) months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
---	------------------------------	-----------------------------

If you answered YES to the above question, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication name <i>(copy off pharmacy label)</i> :	
Date originally prescribed <i>(MM/DD/YYYY)</i> :	
Date prescription last filled <i>(MM/DD/YYYY)</i> :	
Dosage and frequency:	
Diagnosis/condition:	

Medication name <i>(copy off pharmacy label)</i> :	
Date originally prescribed <i>(MM/DD/YYYY)</i> :	
Date prescription last filled <i>(MM/DD/YYYY)</i> :	
Dosage and frequency:	
Diagnosis/condition:	

Medication name <i>(copy off pharmacy label)</i> :	
Date originally prescribed <i>(MM/DD/YYYY)</i> :	
Date prescription last filled <i>(MM/DD/YYYY)</i> :	
Dosage and frequency:	
Diagnosis/condition:	

ATTACH A SEPARATE SHEET IF NEEDED

SECTION VII – Replacement questions

You may be guaranteed acceptance in one or more of our Medicare supplement plans, **IF**:

- You lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy.
- You had certain rights to buy such a policy.

Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS to the best of your knowledge.

1. a) Did you turn age 65 in the last six months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Did you enroll in Medicare Part B in the last six months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please indicate your effective date (From Medicare Health Insurance card, MM/DD/YYYY).		
2. Are you covered for medical assistance through the state Medicaid program? <i>NOTE: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please answer questions a) and b) below.		
a) Will Medicaid pay your premiums for this Medicare supplement policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Do you receive any benefits from Medicaid <i>OTHER THAN</i> payment toward your Medicare Part B premium?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you had coverage from any Medicare plan other than original Medicare within the past sixty three (63) days? (For example, a Medicare Advantage plan, or a Medicare HMO or PPO.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please answer questions a) to g) below.		
a) Name of company:		
Plan type & policy/certificate no.:		
Company telephone number:		
Coverage dates (MM/DD/YYYY):	<i>Start date:</i>	<i>End date:</i>
	<i>If you are still covered under this plan, leave end date blank.</i>	
b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, have you received a copy of the replacement notice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Reason for termination/disenrollment?		
d) Planned date of termination/disenrollment? (MM/DD/YYYY)		

SECTION VII – Replacement questions (*continued*)

e) Was this your first time in this type of Medicare plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g) Is your former Medicare supplement or Medicare select policy/certificate still available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Do you have another Medicare supplement or Medicare select insurance policy in force?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If YES, please answer questions a) to d) below.

a) Name of company:		
Plan type & policy/certificate no.:		
Company telephone number:		
Issue date (MM/DD/YYYY):		
b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Indicate your other in force policy's termination date (MM/DD/YYYY).		
d) Have you received a copy of the replacement notice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you had coverage under any other health insurance within the past sixty three (63) days? (For example, an employer, union, or individual non-Medicare supplement plan.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If YES, please answer questions a) to c) below.

a) Name of company		
Plan type & policy/certificate no.		
Company telephone number		
Coverage dates (MM/DD/YYYY)	<i>Start date:</i>	<i>End date:</i>
	<i>If you are still covered under this plan, leave end date blank.</i>	
b) Reason for termination/disenrollment?		
c) Planned date of termination/disenrollment? (MM/DD/YYYY)		

SECTION VIII – Agent certification

THIS SECTION IS FOR AGENTS ONLY – agents will list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	
Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	

2. List policies sold in the past five (5) years which are no longer in force.

Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	
Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	

SECTION VIII – Agent certification *(continued)*

Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	
Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	
Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	
Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	

SECTION IX – Important statements to be read by the applicant

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid.

If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

- If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan.

If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

SECTION X – Electronic and/or telephonic instructions

In order to process your signature, the Company requests your authorization to act on electronic and/or telephonic instructions from the applicant. Proper identification must be provided. The Company will be held harmless for any claim, liability, loss, or cost, when it has used reasonable procedures to confirm these transactions are authorized and genuine and these procedures have been followed (check one).

I authorize the Company to act on electronic and/or telephonic instructions.

I DO NOT authorize the Company to act on electronic and/or telephonic instructions.

The company also requests your authorization to deliver statements and other documents electronically, **such as by email or Internet**. (check one).

I authorize the Company to electronically deliver statements and other documents. I do have access to the Internet for the purposes of accepting electronic delivery of the documents and a means by which I can provide a current Internet email address.

I DO NOT authorize the Company to electronically deliver statements and other documents.

SECTION XI – Signature and final acknowledgments

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that:

- (a) the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant.
- (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at:

State	Applicant's signature	Date
-------	-----------------------	------

--	--	--	--	--	--	--	--	--	--

Agent writing number	Agent's signature	Date
----------------------	-------------------	------

Policy mailing preference: Mail to Agent Mail to Applicant