CENTRAL STATES HEALTH AND LIFE COMPANY OF OMAHA

Application for Medicare Supplement Coverage

North Carolina

CENTRAL STATES HEALTH & LIFE CO. OF OMAHA
(A Mutual Legal Reserve Company)
Home Office: P.O. Box 34350, Omaha, NE 68134-0350
Administration: P.O. Box 10844, Clearwater, Florida 33757-8844

APPLICATION FOR MEDICARE SUPPLEMENT COVERAGE

SECTION A. PROPOSED INSURED INFORMATION

Applicant Name *(exactly as it appears on your Medicare card)*	
Resident Address	Phone *(with area code)*
City	State, Zip Code
Date of Birth *mm/dd/yyyy*	Current Age
Male ☐ Female ☐	Social Security No
Medicare Card No	
Email Address	

SECTION B. PLAN AND PREMIUM INFORMATION

Plan	Requested Policy Effective Date	Household Premium Discount Yes ☐ No ☐ *If you answered Yes, please answer the statements below.*

Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the following statements:

1. Do you currently live with your spouse, including validly recognized civil union and domestic partners, or do you currently have a household resident (at least one, no more than three) with whom you have continuously resided for the last 12 months? Yes ☐ No ☐
2. If you answered "Yes" to question 1 above, please fill out the following information as it pertains to the member of your household.

Name	
Central States Health & Life Co. of Omaha Medicare Supplement Policy Number *(if household member has an existing policy).*	
Resident Address	
City	State, Zip Code

Premium $		Policy Fee $		
Premium Collected $		Initial Bank Draft: $	Issue Date ☐	Effective Date ☐
Payment Mode:	Monthly ☐ (Bank Draft ONLY)	Annual ☐	Semi-Annual ☐	Quarterly ☐
Payment Method:	Bank Draft ☐		Direct Bill ☐	

SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

1. Are you covered under Medicare Part A?	Yes ☐ No ☐
If NO, what is your future Part A effective date? ____/____/____	
If YES, what is your Part A effective date? ____/____/____	
2. Are you covered under Medicare Part B?	Yes ☐ No ☐
If NO, what is your future Part B effective date? ____/____/____	
If YES, what is your Part B effective date? ____/____/____	
3. If you answered YES to Question #3, have you enrolled in Medicare Part B more than once?	Yes ☐ No ☐
4. Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility).	Yes ☐ No ☐
5. Are you eligible for Medicare due to Disability or End Stage Renal Disease (ESRD)?	Yes ☐ No ☐

IF YES, please check the box that applies. ☐ Disability ☐ End Stage Renal Disease (ESRD)

SECTION D. HEALTH QUESTIONS

If applying during Open Enrollment or a Guaranteed Issue period, go to SECTION F.

If not, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. If you answer YES to any of the following questions 3– 8, you are not eligible for coverage.

1. Height (Feet and inches): _____ Weight (Pounds): _____
2. Have you used tobacco in any form in the past 12 months? Yes ☐ No ☐
3. Do any of the following apply to you:
   a. Currently hospitalized, confined to a bed, in a nursing facility or receiving home health care? Yes ☐ No ☐
   b. Currently residing in an assisted living facility where you receive help with any one or more activities of daily living, including but not limited to bathing, dressing, transferring, toileting, eating and continence? Yes ☐ No ☐
   c. Currently receiving, been advised to have or are considering having occupational, speech, or physical therapy? Yes ☐ No ☐
   d. Currently require the use of a wheelchair or motorized mobility aid or have had any amputation caused by disease? Yes ☐ No ☐
   e. Have been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed, including cataract or joint replacement surgery? Yes ☐ No ☐
   f. Have had medication administered in a physician's office through injection, IV or infusion within the last two years or is currently scheduled or anticipated in the next twelve months (excluding B-12 shots)? Yes ☐ No ☐
   g. Have been hospital confined three or more times in the last two years? Yes ☐ No ☐
   h. Have an implanted cardiac defibrillator or have macular degeneration that has required or will require laser treatment or injections? Yes ☐ No ☐

SECTION D. HEALTH QUESTIONS (continued)

4. At any time have you been medically diagnosed, treated, or had surgery for any of the following:

   a. Emphysema, chronic obstructive pulmonary disease (COPD), sarcoidosis, scleroderma, other chronic pulmonary disorder or any medical condition that requires the use of oxygen? Yes ☐ No ☐

   b. Parkinson's Disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, neuro-muscular disease, osteoporosis with fractures, cirrhosis, chronic hepatitis, kidney disease or insufficiency, kidney failure, or renal failure requiring dialysis? Yes ☐ No ☐

   c. Alzheimer's Disease, dementia, or any other cognitive disorder? Yes ☐ No ☐

   d. Any condition requiring an organ transplant, bone marrow transplant, or stem cell transplant? Yes ☐ No ☐

   e. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? Yes ☐ No ☐

5. If you have diabetes or take prescription medication to control your blood sugar, please answer the following questions (a-d); otherwise answer each question NO.

   a. Do you have complications including peripheral vascular disease, neuropathy, congestive heart failure, any heart condition, kidney disease, kidney failure, or peripheral venous thrombotic disease? Yes ☐ No ☐

   b. Do you have a history of heart attack, stroke, or transient ischemic attack (TIA)? Yes ☐ No ☐

   c. Do you take 3 or more medications to control your blood sugar or 3 or more medications to control your blood pressure? Yes ☐ No ☐

   d. Have you ever required or had a medical professional advise you to take more than 50 units of insulin daily? Yes ☐ No ☐

6. Within the past three years have you had or been treated for or been advised by a physician to have treatment for:

   a. Internal cancer, lymphoma, malignant melanoma, leukemia, Hodgkin's disease? Yes ☐ No ☐

   b. Alcoholism or drug abuse? Yes ☐ No ☐

7. Within the past two years have you been medically diagnosed for any of the following:

   a. Angina, heart disease, heart valve disease, coronary artery disease, carotid artery disease (not including high blood pressure), aortic or cardiac aneurysm, peripheral vascular disease, congestive heart failure, enlarged heart, peripheral venous thrombotic disease, cardiomyopathy, atrial fibrillation, heart rhythm disorders? Yes ☐ No ☐

   b. Spinal stenosis or crippling/disabling arthritis? Yes ☐ No ☐

8. Within the past two years have you had any of the following:

   a. Heart attack, cardiac angioplasty, bypass surgery, or stent placement or replacement? Yes ☐ No ☐

   b. Vascular angioplasty, endarterectomy, or implantation of a pacemaker? Yes ☐ No ☐

   c. Stroke or transient ischemic attacks (TIA)? Yes ☐ No ☐

SECTION D. HEALTH QUESTIONS (continued)

If you answer YES to any of the following health questions 9-12, you may be eligible for coverage.

9. If you answered NO to Questions 7 and 8, please answer questions 9 a & b below. If you do not have any of these conditions, answer each question NO.

   Within the past three years, have you had or been treated for or been advised by a physician to have treatment for:

   a. Angina, heart disease, heart valve disease, coronary artery disease, carotid artery disease, aortic or cardiac aneurysm, peripheral vascular disease, congestive heart failure, enlarged heart, peripheral venous thrombotic disease, cardiomyopathy, atrial fibrillation, heart rhythm disorders? Yes ☐ No ☐

   b. Degenerative bone disease, spinal stenosis, crippling/disabling or rheumatoid arthritis? Yes ☐ No ☐

10. Within the past three years have you had or been treated for or been advised by a physician to have treatment for any mental or nervous disorder requiring psychiatric care? Yes ☐ No ☐

11. If you have diabetes or take any prescription medication(s) to control your blood sugar, do you have diabetic retinopathy or high blood pressure? Yes ☐ No ☐

12. Within the past 12 months have you been hospitalized, treated at an outpatient facility, or emergency room? Yes ☐ No ☐

(Please provide diagnosis and explain any yes answers to questions 9-12 below)

APPLICANT PHYSICIAN INFORMATION

Your Primary Physician:	Phone:
Physician Office Name:	
City:	State:
Specialist seen in the past 24 months:	Specialty:
Reason for seeing (diagnosis):	
Specialist seen in the past 24 months:	Specialty:
Reason for seeing (diagnosis):	
Specialist seen in the past 24 months:	Specialty:
Reason for seeing (diagnosis):	

Have you seen any additional physicians other than those listed above in the past 24 months? Yes ☐ No ☐

SECTION E. MEDICATION HISTORY

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed. Yes ☐ No ☐

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

SECTION F. FOR YOUR PROTECTION, we ask the following questions about insurance policies or certificates you may have.

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, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. 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? Yes ☐ No ☐

   (b) Did you enroll in Medicare Part B in the last six months? Yes ☐ No ☐

   (c) If YES, indicate your effective date. / /

2. Are you covered for medical assistance through the state Medicaid program? Yes ☐ No ☐

   (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to the above question.)
   If YES, answer (a) – (b) below.

   (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes ☐ No ☐

   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes ☐ No ☐

SECTION F. (continued)

3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days? (For example, a Medicare Advantage plan, or a Medicare HMO or PPO.) Yes ☐ No ☐

   If YES, answer (a) – (g) below.

   (a) Name of Company _____

   Plan Type & Policy/Certificate No _____

   Company Telephone Number _____

   Coverage Dates: START DATE / /

   (if you are still covered under this plan, leave end date blank) END DATE / /

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes ☐ No ☐

   If YES, have you received a copy of the replacement notice? Yes ☐ No ☐

   (c) Reason for termination/disenrollment? _____

   (d) Planned date of termination/disenrollment? / /

   (e) Was this your first time in this type of Medicare plan? Yes ☐ No ☐

   (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes ☐ No ☐

   (g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes ☐ No ☐

4. Do you have another Medicare supplement or Medicare select insurance policy in force? Yes ☐ No ☐

   If YES, answer (a) – (d) below.

   (a) Name of Company _____

   Plan Type & Policy/Certificate No _____

   Company Telephone Number _____

   Issue Date / /

   (b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? Yes ☐ No ☐

   (c) Indicate termination date. / /

   (d) Have you received a copy of the replacement notice? Yes ☐ No ☐

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) Yes ☐ No ☐

   If YES, answer (a) – (c) below.

   (a) Name of Company _____

   Plan Type & Policy/Certificate No _____

   Company Telephone Number _____

   Coverage Dates: START DATE / /

   (if you are still covered under this plan, leave end date blank) END DATE / /

   (b) Reason for termination/disenrollment? _____

   (c) Planned date of termination/disenrollment? / /

Agents shall 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
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
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

IMPORTANT STATEMENTS TO BE READ BY 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 reinstituted, 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 reinstituted 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 reinstituted, 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 reinstituted 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).

ELECTRONIC INSTRUCTIONS

Authorization is requested by Central States Health & Life Co. of Omaha (Company) to act on electronic instructions from the applicant, and to electronically deliver statements and other documents to 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 instructions, and to electronically deliver statements and other documents for the purposes of accepting electronic delivery of the documents and a means by which I can provide a current Internet email address. I acknowledge that should I desire to revoke this written authorization, I will inform the Company in writing, of such revocation.

☐ I DO NOT authorize the Company to act on electronic instructions, and to electronically deliver statements and other documents.

Note: I acknowledge that I am responsible for notifying the Company in the event that the email address should change and that I have the option to receive written communication in paper form.

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Central States Health & Life Co. of Omaha, or its reinsurers, any such information. I understand that I am authorizing Central States Health & Life Co. of Omaha to receive my health information and prescription drug usage history. The released information received by Central States Health & Life Co. of Omaha will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Central States Health & Life Co. of Omaha. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Central States Health & Life Co. of Omaha *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Central States Health & Life Co. of Omaha in writing at their Medicare Supplement Administrative Office: P.O. Box 10844, Clearwater, Florida 33757-8844. I understand that such revocation will not have any effect on actions Central States Health & Life Co. of Omaha took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

AUTHORIZATION AND CERTIFICATION (Continued)

I understand and agree that all of the answers to the questions contained in this application are true and complete, and 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; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. I understand that if any answers on this application are incorrect, incomplete or untrue, as to a material fact, Central States Health & Life Co. of Omaha has the right to adjust my premium, reduce my benefits or rescind this policy. 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 makes an intentional misstatement that is material to the risk in an insurance application or presents a false or fraudulent claim, may be found guilty of insurance fraud by a court of law.

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*."

The undersigned hereby agrees to appoint the President and/or Secretary, the continuing proxy to vote for the applicant at any annual, regular or special meeting of the Company at which the applicant may not be present. The annual meeting of members shall be held each year in the home office (1212 North 96th Street, Omaha, Nebraska 68114) on the second Tuesday of January at 10:00 a.m. This proxy shall remain in effect until revoked in writing or until the insurance plan applied for is no longer in effect.

Applicant's Signature	Date	Signed at: State

I certify that I have truly and accurately recorded the information supplied by the Applicant.

C H	Agent's Signature	Date	Signed at: State
Agent Writing Number			

Policy Mailing Preference: ☐ Mail to Agent ☐ Mail to Applicant